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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 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 or suspension 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 Chapters 78 and 79

Inspections and Appeals Department[481]

Replace Chapter 52

Law Enforcement Academy[501]

Replace Analysis

Replace Chapters 1 to 3

Replace Chapters 6 to 8

Replace Chapter 10

Professional Licensure Division[645]

Replace Analysis

Replace Chapter 20

Replace Chapters 31 and 32

Pharmacy Board[657]

Replace Chapter 3

Replace Chapters 6 to 8

Replace Chapter 13

Replace Chapter 17

Replace Chapter 21

Replace Chapters 42 and 43

Veterans Affairs, Iowa Department of[801]

Replace Chapter 14

Labor Services Division[875]

Replace Chapter 10

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

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

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

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

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

78.1(1) Payment will not be made for:

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

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

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

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

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

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

(1) Colostomy and ileostomy appliances.

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

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

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

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

d. Rescinded IAB 1/30/08, effective 4/1/08.

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

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

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

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

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

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

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

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

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

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

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

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

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

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

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

(3) Augmentation mammoplasties.

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

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

(6) Panniculectomy and body sculpture procedures.

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

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

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

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

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

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

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

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

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

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

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

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

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

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

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

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

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

78.1(11) 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(4))

78.1(19) Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the IME medical services unit and the department. If not so approved by the IME medical services unit, payment will not be made under the

program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

78.1(20) Transplants.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.1(23) 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 version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

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

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

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

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

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

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

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

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. Pursuant to Public Law 111-148, Section 6401, any practitioner prescribing drugs must be enrolled with the Iowa Medicaid enterprise in order for such prescribed drugs to be eligible for payment.

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.

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

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

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

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

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

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

b. Payment is not made for:

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

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

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

(4) Rescinded IAB 2/8/12, effective 3/14/12.

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

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

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

(8) Drugs prescribed for fertility purposes.

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

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

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

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

78.2(5) Nonprescription drugs.

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

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

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

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

78.2(6) Quantity prescribed.

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

b. *Prescription refills.*

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

(2) Automatic refills.

1. Automatic refills are not allowed. A request specific to each medication is required.

2. All prescription refills shall be initiated by a request at the time of each fill by the prescriber, Medicaid member or person acting as an agent of the member, based on continued medical necessity.

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

78.2(8) Consultation. In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not

required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

78.3(8) 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 the IME medical services unit to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

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

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

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

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

for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

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

(1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.
 (2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16) “a.”

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

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

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

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

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

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

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

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

78.3(17) Rescinded IAB 8/9/89, effective 10/1/89.

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

78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

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

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

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

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

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

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

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

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

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

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

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

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

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

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

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

i. Temporomandibular joint radiograph.

j. Cephalometric film.

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

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

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

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

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

c. Rescinded IAB 5/1/02, effective 7/1/02.

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

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

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

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow

restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

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

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

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

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

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

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

(4) Rescinded IAB 5/1/02, effective 7/1/02.

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

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

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

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

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

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

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

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

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

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

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

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

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

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

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

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

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

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

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

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

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

a. Extractions, both surgical and nonsurgical.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

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

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

(2) Gonioscopy.

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

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

(5) External photography.

(6) Fundus photography.

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

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

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

1. Ordering of corrective lenses.

2. Verification of lenses after fabrication.

3. Adjustment and alignment of completed lens order.

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

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

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

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

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

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

1. Children through seven years of age.

2. Members with vision in only one eye.

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

e. 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 seven years of age.

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

(3) Safety frames are allowed for:

1. Children through seven years of age.

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

g. 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 one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or

chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

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

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

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

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

- a. Materials payable by fee schedule are:
 - (1) Spectacle lenses, single vision and multifocal.
 - (2) Frames.
 - (3) Case for glasses.
- b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:
 - (1) Contact lenses.
 - (2) Schroeder shield.
 - (3) Ptosis crutch.
 - (4) Safety frames.
 - (5) Subnormal visual aids.
 - (6) Photochromatic lenses.

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

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

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

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

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

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

(Cross reference 78.28(4))

78.6(5) Noncovered services. Noncovered services include, but are not limited to, the following services:

- a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

- b. Glasses for occupational eye safety.
- c. A second pair of glasses or spare glasses.
- d. Cosmetic surgery and experimental medical and surgical procedures.
- e. Sunglasses.
- f. Progressive bifocal or trifocal lenses.

78.6(6) *Therapeutically certified optometrists.* Rescinded IAB 9/5/12, effective 11/1/12.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross reference 78.28(4))

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.

[ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of “pain” is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient’s condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0- G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30- M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35- M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21- M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20- M50.23	Other cervical disc displacement
M47.811- M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30- M50.33	Other cervical disc degeneration
M47.891- M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00- M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24- M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34- M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M54.5	Low back pain	M46.00- M46.09	Spinal enthesopathy	M54.30- M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41- M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40- M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00- M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.9	Dorsalgia, unspecified	M50.10- M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80- M50.83	Other cervical disc disorders		
		M50.90- M50.93	Cervical disc disorder, unspecified		
		M51.14- M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84- M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1- M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84- M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10- M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20- M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30- M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40- M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50- M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60- M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		M99.70- M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

* NEC means not elsewhere classified.

b. The neuromusculoskeletal conditions listed in the table in paragraph “*a*” generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.
- (2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient’s condition.
- (3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) Documenting X-ray. An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph “*c*” of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient’s name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient’s clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which

major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph “a” of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph “a” of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor’s office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician 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 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. The

plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
 - (1) Dates of prior hospitalization.
 - (2) Dates of prior surgery.
 - (3) Date last seen by a physician.
 - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 - (5) Prognosis.
 - (6) Functional limitations.
 - (7) Vital signs reading.
 - (8) Date of last episode of instability.
 - (9) Date of last episode of acute recurrence of illness or symptoms.
 - (10) Medications.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 60 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's 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. Rescinded IAB 3/29/17, effective 5/3/17.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

- (1) The potential risk factors,
- (2) The medical factor or symptom which verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide

sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.
- (8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.
- (4) Preexisting mental or physical disabilities such as deaf, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.
- (5) Drug or alcohol abuse.
- (6) Symptoms of postpartum psychosis.
- (7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.
- (8) Demonstrated disturbance in maternal and infant bonding.
- (9) Discharge or release from hospital against medical advice before 36 hours postpartum.
- (10) Insufficient antepartum care by history.
- (11) Multiple births.
- (12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

- (1) Birth weight of five pounds or under or over ten pounds.
- (2) History of severe respiratory distress.
- (3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.
- (4) Disabling birth injuries.

- (5) Extended hospitalization and separation from other family members.
 - (6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.
 - (7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.
 - (8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.
 - (9) Discharge or release against medical advice before 36 hours of age.
 - (10) Nutrition or feeding problems.
- e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:
- (1) Child or sibling victim of child abuse or neglect.
 - (2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.
 - (3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.
 - (4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.
 - (5) Malignancies such as leukemia or carcinoma.
 - (6) Severe injuries necessitating treatment or rehabilitation.
 - (7) Disruption in family or peer relationships.
 - (8) Suspected developmental delay.
 - (9) Nutritional deficiencies.

78.9(10) Private duty nursing or personal care services for persons aged 20 and under. Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

- 1. Respite care, which is a temporary intermission or period of rest for the caregiver.
- 2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
- 3. Services provided to other persons in the member's household.
- 4. Services requiring prior authorization that are provided without regard to the prior authorization process.
- 5. Transportation services.
- 6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include

nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.28(10))

78.9(11) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 3005C, IAB 3/29/17, effective 5/3/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) General payment requirements. Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the

expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.
- (6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5) "k" for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5) "n" for prior authorization requirements.

78.10(2) Durable medical equipment. DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

5. Oxygen prescribed “PRN” or “as necessary” is not payable.

6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5) “*f*” for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser. See 78.10(5) “*d*” for prior authorization requirements.

Bathtub/shower chair, bench. See 78.10(5) “*g*” and “*j*” for prior authorization requirements.

Commode, shower commode chair. See 78.10(5) “*j*” for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5) “*a*” for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5) “*c*” for prior authorization requirements.

Insulin infusion pump. See 78.10(5) “*b*” and 78.10(5) “*e*” for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5) “*i*” for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2) “*a*” and 78.10(2) “*c*.”

Patient lift. See 78.10(5) “*h*” for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5) "f" for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed "PRN" or "as necessary" is not allowed.

d. Wheelchairs, wheelchair accessories, and wheelchair modifications are covered when they are medically necessary for mobility within the home, nursing facility, or intermediate care facility. Wheelchairs are defined as:

(1) Standard manual wheelchairs. Coverage of a standard manual wheelchair includes the following:

1. Complete set of tires/wheels and casters, any type;
2. Hand rims with or without projections;
3. Weight-specific components required by the patient-weight capacity of the wheelchair;
4. Elevating legrest, lower extension tube and upper hanger bracket;
5. Armrest (detachable, non-adjustable or adjustable) with or without arm pad;
6. Footrest (swingaway, detachable), including lower extension tube(s) and upper hanger bracket;
7. Standard size footplates;
8. Wheelchair bearings;
9. Caster fork, replacement only; and
10. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(2) Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:

1. Headrest extensions;
2. One-arm drive attachments;
3. Positioning accessories;
4. Specialized skin protection seat and back cushions; and
5. Anti-rollback devices.

(3) Standard power wheelchair. Coverage of a standard power wheelchair requires prior authorization and includes the following:

1. Lap belt or safety belt;

2. Battery charger, single mode;
3. Complete set of tires/wheels and casters, any type;
4. Legrests (fixed, swingaway, or detachable non-elevation legrests with or without calf pad);
5. Footrests/foot platform (fixed, swingaway, detachable footrests or a foot platform without angle adjustment, single adjustable footplate);
6. Armrests (fixed, swingaway, detachable non-adjustable height armrests with arm pad provided);
7. Any weight-specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient-weight capacity of the wheelchair;
8. Any seat width and depth. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
9. Any back width. For power wheelchairs with a sling/solid seat/back, the following may be billed separately:
 - For standard duty, seat width and/or depth greater than 20 inches;
 - For heavy duty, seat width and/or depth greater than 22 inches;
 - For very heavy duty, seat width and/or depth greater than 24 inches;
 - EXCEPTION: For extra heavy duty, there is no separate billing;
10. Non-expandable controller or standard proportional joystick (integrated or remote); and
11. All labor charges involved in the assembly of the wheelchair (including, but not limited to: front caster assembly, rear wheel assembly, ratchet assembly, wheel lock assembly, footrest assembly).

(4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:

1. Shoulder harness/straps or chest straps/vest;
2. Elevating legrest;
3. Angle adjustable footplates;
4. Adjustable height armrests; and
5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).

(5) Customized items are payable with a prior authorization, in accordance with 42 CFR §414.224.

78.10(3) Prosthetic devices. Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.

b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:

- (1) Artificial eyes.
- (2) Artificial limbs.
- (3) Enteral delivery supplies and products. See 78.10(5) "l" for prior authorization requirements.
- (4) Hearing aids. See rule 441—78.14(249A).
- (5) Orthotic devices. See 78.10(3) "c" for limitations on coverage of cranial orthotic devices.
- (6) Ostomy appliances.
- (7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).

(9) Tracheotomy tubes.

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference 78.28(5))

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member's gender and age; or

2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) Medical supplies. Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5) "e" for prior authorization requirements.

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Incontinence products (for members three years of age and older).

Oral nutritional products. See 78.10(5) "m" for prior authorization requirements.

Ostomy appliances and supplies.

Respirator supplies.

Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Ostomy appliances and supplies.

Shoes, diabetic.

78.10(5) Prior authorization requirements. Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member's mobility puts the member at risk for injury.

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.

(2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

d. 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 per 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.

e. Diabetic equipment and supplies. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with

expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

- (1) Has a sip 'n puff attachment, or
- (2) The medical documentation demonstrates the member's difficulty operating the wheelchair in tight space, or
- (3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

- (1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and
- (2) Needs upper body support while sitting, and
- (3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

- (1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and
- (2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider's cost to obtain the equipment or supply.

o. Customized wheelchairs, subject to the requirements of 78.10(2)"d."

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate

facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

- a. The individual is admitted as a hospital inpatient or in an emergency situation.
- b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

- One patient - normal allowance
- Two patients - 3/4 normal allowance per patient
- Three patients - 2/3 normal allowance per patient
- Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5) "j."

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

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

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

78.12(1) Definitions.

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;
2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and
3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

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

"Mental disorder" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced

movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) Covered services.

a. Service setting.

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. Crisis intervention. Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. Behavior intervention. Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. Family training. Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;

2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and

3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,
2. Conflict resolution skills,
3. Daily living skills,
4. Employment-related skills,
5. Interpersonal relationship skills,
6. Problem-solving skills, and
7. Social skills.

78.12(3) Excluded services.

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) Coverage requirements. Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,
2. Behavioral support in the community,
3. Specific skills impaired due to the member's mental illness, and
4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) Approval of plan. The behavioral health intervention provider shall contact the Iowa Plan provider for authorization of the services.

a. Initial plan. The initial services implementation plan must meet all of the following criteria:

- (1) The plan conforms to the medical necessity requirements in subrule 78.12(6);
- (2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;
- (3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
- (4) The provider meets the requirements of rule 441—77.12(249A); and
- (5) The plan does not exceed six months' duration.

b. Subsequent plans. The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:

- (1) Reexamined the member;
- (2) Reviewed the original diagnosis and treatment plan; and
- (3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)“c”(3).

78.12(6) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, “medically necessary” means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

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

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

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

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
- (2) The professional literature regarding evidence-based practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) Covered services. Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

- (1) Mileage reimbursement to the member, if the member is the driver.
- (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
- (3) Taxi service.
- (4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.
- (5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;

2. Unexpected preoperative appointments;

3. Hospital discharges;

4. Appointments for new medical conditions or tests; and

5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;

2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and

3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

- (1) Whether the member owns a vehicle;
- (2) Whether a member-owned vehicle is in working mechanical order and is licensed;
- (3) Whether the member has a valid driver's license and auto insurance;
- (4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and
- (5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

- (1) The transportation being provided spans the entire meal period;
- (2) The one-way distance to or from the medical appointment is more than 50 miles;
- (3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and
- (4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

- (1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or
- (2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or
2. The member's prior experience with the requested provider; or
3. The requested provider's special expertise or experience; or
4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.

- a. Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”
- b. Transportation providers.
 - (1) Consent for state fair hearing.
 - 1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.
 - 2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member’s lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.
 - 3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider’s bringing the state fair hearing on the member’s behalf.
 - (2) For all transportation provider grievances not addressed by paragraph 78.13(4)“b,” the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

- a. Has been advised that it may be in the member’s best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.
- b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member’s condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member’s condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member’s place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

- a. A child needs the aid for speech development,

- b. The aid is needed for educational or vocational purposes,
- c. The aid is for a blind member,
- d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
- e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1) "a."

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference 78.28(5) "a")

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(5) "b"):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

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

[ARC 8008B, IAB 7/29/09, effective 8/1/09; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

"Custom-molded shoe" means a shoe that:

- 1. Has been constructed over a cast or model of the recipient's foot;
- 2. Is made of leather or another suitable material of equal quality;
- 3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
- 4. Has some form of closure.

"Depth shoe" means a shoe that:

- 1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
- 2. Is made from leather or another suitable material of equal quality;

3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

“Insert” means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) Diagnosis. The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) Frequency. Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1) “*b*” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified

psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

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

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Six screenings in the first year of life.
- (2) Four screenings between the ages of 1 and 2.
- (3) One screening a year at ages 3, 4, 5, and 6.
- (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) 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.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) Coverage of services.

a. General provisions regarding coverage of services.

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided to a member residing in a residential care facility are payable when the facility submits a signed statement 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 member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability since these facilities are responsible for providing or paying for services required by members.

(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.
[ARC 0994C, IAB 9/4/13, effective 11/1/13]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) 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).)

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.

78.25(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's website.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;
- b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and
- c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

- a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.
- b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.
- c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference 78.28(7))

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

[ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Medicaid enterprise. Effective March 17, 2022, payment shall only be made for services provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.27(1) Definitions.

“*Adult*” means a person who is 18 years of age or older.

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Benefits education*” means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

“*Care coordinator*” means the professional who assists members in care coordination as described in paragraph 78.53(1) “b.”

“*Career exploration*,” also referred to as “career planning,” means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the participant’s stated career objective and a career plan used to guide individual employment support.

“*Career plan*” means a written plan documenting the member’s stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state’s minimum wage.

“*Case management*” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“*Comprehensive service plan*” means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

“*Customized employment*” means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

“Department” means the Iowa department of human services.

“Emergency” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

“HCBS” means home- and community-based services.

“Individual employment” means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

“Individual placement and support” means an evidence-based supported employment model that helps people with mental illness to seek and obtain employment.

“Integrated community employment” means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

“Integrated health home” means the provision of services to enrolled members as described in subrule 78.53(1).

“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.

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

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

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

“Supported employment” means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state’s minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

“Supported self-employment” includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

“Sustained employment” means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

- a. *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 interRAI - Child and Youth Mental Health (ChYMH) for youth aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older has been completed, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The interRAI - Child and Youth Mental Health (ChYMH) and the interRAI - Community Mental Health (CMH) information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the interRAI, before services begin and annually thereafter.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4), before services begin and annually thereafter.

e. Plan for service. The department has approved the member's comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). 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 member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team as selected by the member or the member's legal representative. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved with the member.

(2) With assistance from the member and the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager or integrated health home care coordinator within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;

2. The funding source for the service; and

3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;

2. The number of hours per day of on-site staff supervision needed by the member; and

3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;
- (2) The need for the restriction; and
- (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

- (1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

- (2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

- (3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2) "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—90.4(249A) through 441—90.7(249A).

- b. Exclusions.*

- (1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

- (2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living 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 community-based, nonresidential settings separate from the member's residence.

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 service habilitation. “Prevocational services” means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member’s experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member’s local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member’s family, guardian or legal representative to introduce them to supported employment and explore the member’s employment goals and experiences,

2. Business tours,
3. Informational interviews,
4. Job shadows,
5. Benefits education and financial literacy,
6. Assistive technology assessment, and
7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member’s individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

d. Exclusions. Prevocational services payment shall not be made for the following:

- (1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

e. Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9)"a"(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9)"a"(1). This time limit can be extended as stated in paragraphs 78.27(9)"e"(1)"1" through "6." If the criteria in paragraphs 78.27(9)"e"(1)"1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) Supported employment services.

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10) "a"(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.

b. Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) *Scope.* Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) *Expected outcome of service.* The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) *Setting.* Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

(4) *Service activities.* Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.

(5) *Self-employment long-term job coaching.* Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10) "b"(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

(6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member's comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight

workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.

11. Transportation of the member during service hours.

d. Service requirements for all supported employment services.

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

e. Limitations. Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed \$3,059.29 per month.

(3) Individual supported employment is limited to 240 units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

f. Exclusions. Supported employment services payments shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) *Adverse service actions.*

a. Denial. Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 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. Rescinded IAB 7/11/12, effective 7/1/12.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. Payment shall be approved pursuant to the criteria at 78.10(5)“d.”

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5)“l.”

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5)“f.”

f. Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies

to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department and the IME medical services unit. If not so approved by the IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

- g.* Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5)“*a.*”
- h.* Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2)“*c.*”)
- i.* Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5)“*m.*”
- j.* Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5)“*c.*”
- k.* Diabetic equipment and supplies. Payment will be approved pursuant to the criteria at 78.10(5)“*e.*”
- l.* Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5)“*n.*”
- m.* Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5)“*g.*”
- n.* Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5)“*h.*”
- o.* Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5)“*i.*”
- p.* Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5)“*j.*”
- q.* Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.
- r.* Customized wheelchairs, subject to the requirements of 78.10(2)“*d.*”

78.28(2) Notwithstanding the provisions of 78.28(1)“*a.*” under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

- a.* Buprenorphine,
- b.* Buprenorphine and naloxone combination,
- c.* Methadone,
- d.* Naltrexone, and
- e.* Naloxone.

For the purpose of this subrule, “medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with treatment services.

78.28(3) Dental services. Dental services which require prior approval are as follows:

- a.* The following periodontal services:
 - (1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4)“*b.*”
 - (2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4)“*d.*”
 - (3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4)“*e.*”
 - (4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4)“*f.*”
 - (5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4)“*g.*”
- b.* The following prosthetic services:
 - (1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“*b.*”
 - (2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“*d.*”

(3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“c.”

(4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“e.”

(5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)“k.”

(6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)“l.”

(7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)“m.”

(8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)“n.”

c. The following orthodontic services:

(1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8)“a.”

(2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“b.”

(3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)“c.”

d. The following restorative services:

(1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3)“d”(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3)“d”(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5)“d.”

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9)“g.”

78.28(4) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

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

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

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

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

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

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(5) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person’s hearing that would require a different hearing aid. (Cross reference 78.14(7)“d”(1))

b. A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7)“d”(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(6) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross reference 441—78.3(249A))

c. Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department. The criteria are available from the IME medical services unit.

78.28(7) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review 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(8) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(9) Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or

behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

78.28(10) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work

toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

78.28(11) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3) “b”)

78.28(12) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(12) “b,” the following radiology procedures require prior approval:

- (1) Magnetic resonance imaging (MRIs);
- (2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
- (3) Computed tomographic angiographs (CTAs);
- (4) Positron emission tomography (PETs); and
- (5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(12) “a,” prior authorization is not required when any of the following applies:

- (1) Radiology procedures are billed on a CMS 1500 claim for places of service “hospital inpatient” (POS 21) or “hospital emergency room” (POS 23), or on a UB04 claim with revenue code 45X;
- (2) The member has Medicare coverage;
- (3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member’s receipt of such notice (see paragraph 78.28(12) “e”); or
- (4) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted through the online system operated by the department’s contractor for prior approval of high-technology radiology procedures.

e. Services are billed for members with retroactive eligibility.

(1) When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member’s receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-0829, Request for Prior Authorization, before any claim for payment is submitted.

(2) Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.

(3) Retroactive authorizations will not be granted when sought for reasons other than a member’s retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:

1. The provider was unaware of the high-technology radiology prior authorization requirement.
2. The provider was unaware that the member had current Medicaid eligibility or coverage.
3. The provider forgot to complete the required prior authorization process.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0631C, IAB 3/6/13, effective 5/1/13; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations.

- a. An assessment and a treatment plan are required.
- b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:

- a. Services provided in a medical institution.
- b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.
- c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.
- d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

- a. Payment shall be made only for time spent in face-to-face consultation with the member.
- b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

- a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.
- b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs "g" to "m" are subject to a random sample retrospective review for medical necessity by the IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs "a" to "f" shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs "g" to "m" shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a. Emergency service.
- b. Outpatient surgery.
- c. Laboratory, X-ray and other diagnostic services.
- d. General or family medicine.

- e.* Follow-up or after-care specialty clinics.
- f.* Physical medicine and rehabilitation.
- g.* Alcoholism and substance abuse.
- h.* Eating disorders.
- i.* Cardiac rehabilitation.
- j.* Mental health.
- k.* Pain management.
- l.* Diabetic education.
- m.* Pulmonary rehabilitation.
- n.* Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs “*d*” and “*f*” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

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

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs “*g*” to “*m*,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

- a.* Documented need for the program including studies, needs assessments, and consultations with other health care professionals.
- b.* Goals and objectives of the program.
- c.* Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) Requirements for specific types of service.

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, Mallory-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.
[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).
2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children's mental health waiver.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek

employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.34(2) *Home health services.* Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) *Nursing care services.* Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be

used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7) "f" and the skilled activities listed in paragraph 78.34(7) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
 - (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
 - (8) Colostomy care.
 - (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
 - (10) Postsurgical nursing care.
 - (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
 - (12) Preparing and monitoring response to therapeutic diets.
 - (13) Recording and reporting of changes in vital signs to the nurse or therapist.
- h. Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):
- (1) Any activity related to supervising a member. Only direct services are billable.
 - (2) Any activity that the member is able to perform.
 - (3) Costs of food.
 - (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
 - (5) Exercise that does not require skilled services.
 - (6) Parenting or child care for or on behalf of the member.
 - (7) Reminders and cueing.
 - (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
 - (9) Transportation costs.
 - (10) Wait times for any activity.

78.34(8) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
 - (2) During a search for employment by a usual caregiver,
 - (3) To allow for academic or vocational training of a usual caregiver,
 - (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
 - (5) Due to the death of a usual caregiver.
- b. Service requirements.* Interim medical monitoring and treatment services shall:
- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
 - (2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

- 1. An in-home medical communications transceiver.
- 2. A remote, portable activator.
- 3. A central monitoring station with backup systems staffed by trained attendants at all times.
- 4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

- 1. A portable communications transceiver or transmitter to be worn or carried by the member.
- 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of

the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13) "g" and employer authority tasks identified in paragraph 78.34(13) "h," or who delegates the budget or employer authority tasks identified in paragraph 78.34(13) "i." Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.

9. Transportation.
- (3) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:
 1. Consumer-directed attendant care (unskilled).
 2. Home-delivered meals.
 3. Homemaker service.
 4. Basic individual respite care.
- (4) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability waiver are:
 1. Consumer-directed attendant care (unskilled).
 2. Day habilitation.
 3. Home and vehicle modification.
 4. Prevocational services.
 5. Basic individual respite care.
 6. Supported community living.
 7. Supported employment.
 8. Transportation.
- (5) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:
 1. Consumer-directed attendant care (unskilled).
 2. Home and vehicle modification.
 3. Prevocational services.
 4. Basic individual respite care.
 5. Specialized medical equipment.
 6. Supported community living.
 7. Supported employment.
 8. Transportation.
- (6) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:
 1. Consumer-directed attendant care (unskilled).
 2. Home and vehicle modification.
 3. Specialized medical equipment.
 4. Transportation.
- (7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13) "b"(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.
- (8) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.
- (9) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.
- (10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13) "b"(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13) "b"(8).
- (11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13) "b"(7) or the utilization adjustment factor in subparagraph 78.34(13) "b"(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included

in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid enterprise or managed care organization as the least costly option to meet the member's need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member's service plan and authorized by the case manager or community-based case manager.

(12) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)"d." At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member's service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed

community supports and services may exceed the amount of service or supports authorized in the member's service plan. Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
 2. Clothing not related to an assessed medical need.
 3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
 4. Costs associated with shipping items to the member.
 5. Experimental and non-FDA-approved medications, therapies, or treatments.
 6. Goods or services covered by other Medicaid programs.
 7. Home furnishings.
 8. Home repairs or home maintenance.
 9. Homeopathic treatments.
 10. Insurance premiums or copayments.
 11. Items purchased on installment payments.
 12. Motorized vehicles.
 13. Nutritional supplements.
 14. Personal entertainment items.
 15. Repairs and maintenance of motor vehicles.
 16. Room and board, including rent or mortgage payments.
 17. School tuition.
 18. Service animals.
 19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
 20. Sheltered workshop services.
 21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
 22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
 23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member's service plan.
 24. Residential services provided to three or more members living in the same residential setting.
- (4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13)"b"(11).

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)"d." The savings plan shall meet the requirements in paragraph 78.34(13)"f."

f. Savings plan. A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member's managed care organization for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member's service needs identified in the member's service plan.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

5. Specific time spans for accumulating the savings allocation, not to exceed the member's current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member's service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member's waiver year in which the saving occurred.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).
- (3) Schedule the provision of services. A contingency plan must be established in the member's service plan to ensure service delivery in the event the member's employee is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget. When the member's guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13) "i."

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member's service plan. The member or the delegated employer authority may perform the following functions:

- (1) Recruit and hire employees.
- (2) Verify employee qualifications.
- (3) Specify additional employee qualifications.
- (4) Determine employee duties.

- (5) Determine employee wages and benefits.
- (6) Schedule employees.
- (7) Train and supervise employees.

i. Delegation of budget and employer authority. The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13)“g” and employer authority tasks identified in paragraph 78.34(13)“h.” Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member’s service plan.

- (1) The representative must be at least 18 years old.
- (2) The representative shall not be a current provider of service to the member.
- (3) The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.
- (4) The representative shall not be paid for this service.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member’s representative:

- (1) Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member’s individual budget has addressed the member’s needs and the satisfaction of the member.

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) Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.
- (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

- (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
- (6) Verify for the member an employee's citizenship or alien status.
- (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 6. Preparing and issuing employee payroll checks.
 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 8. Processing federal advance earned income tax credit for eligible employees.
 9. Refunding over-collected FICA, when appropriate.
 10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.
- (18) The department may request that the financial management service provider withhold payment to any member or member's employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).
 - m. Responsibilities of the member and the employee.* A member participating in the CCO and the member's employee(s) are responsible for the following:
 - (1) A member participating in the CCO shall be jointly and severally liable with any of the member's employees for any overpayment of medical assistance funds used through a CCO budget.
 - (2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, "sanction" also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.
 - (3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.
 - (4) Employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. Documentation shall comport with 441—subparagraph 79.3(2) "c"(3), "Service documentation."
 - (5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13) "m"(4) prior to the timecard's submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately

describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

78.34(14) General service standards. All ill and handicapped waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

- (2) Medical social services.
- (3) Physician services.
- (4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.
- (5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.
- (6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.
- (7) Homemaker and home health aide services.
- (8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.
- (9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

- (1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.
- (2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.
- (3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.
- (4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

- a.* Routine home care is care provided in the place of residence that is not continuous.
- b.* Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.
- c.* Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.
- d.* General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility,

the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

- a. The resident is terminally ill.
- b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.
- c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) Approval for hospice benefits. Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. *Physician certification process.* The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. *Election procedures.* Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3553C, IAB 1/3/18, effective 2/7/18]

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.37(1) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

- (1) The necessary components of a system are:
 1. An in-home medical communications transceiver.
 2. A remote, portable activator.
 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

- a. Observation and reporting of physical or emotional needs.
- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.37(5) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) *Chore services.* Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7)“*a*,” as necessary to allow a member to remain in the member’s own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

- (1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;
- (2) Minor repairs to walls, floors, stairs, railings and handles;
- (3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;
- (4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member’s residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member’s service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.37(9) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member’s home or vehicle that directly address the member’s medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member’s medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member’s disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) Mental health outreach. Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) Nutritional counseling. Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) Assistive devices. Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) Senior companion. Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)“f” and the skilled activities listed in paragraph 78.37(15)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.37(16) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.37(17) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) Assisted living service. The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

a. A unit of service is one day.

b. A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day's bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

78.37(19) General service standards. All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

- (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
 - (2) The need for the restriction.
 - (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
 - (6) The informed consent of the member.
 - (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
 - e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2340C, IAB 1/6/16, effective 2/10/16; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a. Observation and reporting of physical or emotional needs.

- b. Helping a client with bath, shampoo, or oral hygiene.
- c. Helping a client with toileting.
- d. Helping a client in and out of bed and with ambulation.
- e. Helping a client reestablish activities of daily living.
- f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

- a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
- c. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

- a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.
- b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.
- h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

- a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.38(7) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) "f" and the skilled activities listed in paragraph 78.38(8) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.38(9) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.38(10) General service standards. All AIDS/HIV waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

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

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member’s home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member’s rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member’s needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member’s personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life’s activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member’s functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human

body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect costs associated with members' specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1) "f"(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

- c. A unit of service is 15 minutes.
- d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
- e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
- f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
- g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.
- h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.
- i. Payment for respite services shall not exceed \$7,334.62 per the member's waiver year.

78.41(3) *Personal emergency response or portable locator system.*

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

- (1) The necessary components of the system are:
 - 1. An in-home medical communications transceiver.
 - 2. A remote, portable activator.
 - 3. A central monitoring station with backup systems staffed by trained attendants at all times.
 - 4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.
- (2) The service shall be identified in the member's service plan.
- (3) A unit of service is a one-time installation fee or one month of service.
- (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

- (1) The required components of the portable locator system are:
 - 1. A portable communications transceiver or transmitter to be worn or carried by the member.
 - 2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
- (2) The service shall be identified in the member's service plan.
- (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
- (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) Nursing services. Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) Home health aide services. Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) Supported employment services. Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8)“f” and the skilled activities listed in paragraph 78.41(8)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.

- (2) Ensure appropriate assessment, planning, implementation, and evaluation.

- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

- (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

- (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
- (8) Colostomy care.
- (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

- (1) Any activity related to supervising a member. Only direct services are billable.
- (2) Any activity that the member is able to perform.
- (3) Costs of food.
- (4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

- (5) Exercise that does not require skilled services.
- (6) Parenting or child care for or on behalf of the member.
- (7) Reminders and cueing.
- (8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
- (9) Transportation costs.
- (10) Wait times for any activity.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 hours of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) Residential-based supported community living services. Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“*d.*”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member's service plan.

78.41(12) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) Prevocational services. Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) Day habilitation services.

a. Scope. Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member'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 member's home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Unit of service. Except as provided in paragraph 78.41(14) "b," the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

d. Exclusions.

(1) Services shall not be provided in the member's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member'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 is service activities provided pursuant to subrule 78.34(13).

78.41(16) General service standards. All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

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 (VFC) Program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

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

[ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

78.43(2) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)"e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) Supported employment services. Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically

included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

- (1) The necessary components of a system are:
 1. An in-home medical communications transceiver.
 2. A remote, portable activator.
 3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 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.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25

to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

- a. A complete assessment of both appropriate and maladaptive behaviors.
- b. Development of a structured behavioral intervention plan which should be identified in the ITP.
- c. Implementation of the behavioral intervention plan.
- d. Ongoing training and supervision to caregivers and behavioral aides.
- e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13) "f" and the skilled activities listed in paragraph 78.43(13) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

- (1) Retain accountability for actions that are delegated.
- (2) Ensure appropriate assessment, planning, implementation, and evaluation.
- (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

- (1) Dressing.
- (2) Bathing, shampooing, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
- (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
- (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping, laundry, and shopping essential to the member's health care at home.
- (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
- (8) Minor wound care.
- (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
- (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
- (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.43(14) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member's home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised;

and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

- (1) Is medically stable;
- (2) Does not require a level of care that includes more intensive medical monitoring;
- (3) Presents a low risk to self, others, or property, with treatment and support; and
- (4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

- (1) Treatment objectives and outcomes,
- (2) The expected frequency and duration of each service,
- (3) The location where the services will be provided,
- (4) A crisis plan, and
- (5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. *Evaluation and medication management.*

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. *Integrated therapy and counseling for mental health and substance abuse.* This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. *Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. *Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. *Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

- (1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and
- (2) Ensuring that the member keeps appointments.

f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.
2. Assisting the member in gaining access to necessary medical, social, educational, and other services.
3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.
2. Make referrals to services and related activities to assist the member with the assessed needs.
3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.
4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

- (1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.
- (2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.
- (3) Providing supports to maintain employment, such as crisis intervention related to employment.
- (4) Teaching communication, problem solving, and safety skills.
- (5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1) "f" and the skilled activities listed in paragraph 78.46(1) "g." Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) "b," the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to \$6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) Specialized medical equipment.

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.46(7) General service standards. All physical disability waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.
- c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
 - (1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
 - (2) The need for the restriction.
 - (3) The less intrusive methods of meeting the need that have been tried but did not work.
 - (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
 - (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
 - (6) The informed consent of the member.
 - (7) An assurance that the interventions and supports will cause no harm to the member.
 - (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
- d. Services must be billed in whole units.
- e. For all services with a 15-minute unit of service, the following rounding process will apply:
 - (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
 - (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
 - (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
 - (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter]

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) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0358C, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. “Case management” means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child’s planned discharge if the child’s stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child’s planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child’s service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child’s history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;

- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child's strengths and preferences;
- (2) Consider the child's physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child's medical, social, educational, and other service needs.

These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.

2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.

4. Scheduling appointments for the child.

5. Facilitating the timely delivery of services.

6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.

2. Whether the services in the plan of care are adequate to meet the needs of the child.

3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

(1) The name of the child;

(2) The dates of case management services;

(3) The agency chosen by the family to provide the case management services;

(4) The nature, content, and units of case management services received;

(5) Whether the goals specified in the care plan have been achieved;

(6) Whether the family has declined services in the care plan;

(7) Time lines for providing services and reassessment; and

(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

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

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) *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.

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established

in 441—Chapter 83 and as identified in the member's service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) General service standards. All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) Environmental modifications and adaptive devices.

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) Family and community support services. Family and community support services shall support the member and the member's family by the development and implementation of strategies and

interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.

a. Dependent on the needs of the member and the member's family members individually or collectively, family and community support services may be provided to the member, to the member's family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member's interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

(1) Developing and maintaining a crisis support network for the member and for the member's family.

(2) Modeling and coaching effective coping strategies for the member's family members.

(3) Building resilience to the stigma of serious emotional disturbance for the member and the family.

(4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

(5) Modeling and coaching the strategies and interventions identified in the member's crisis intervention plan as defined in 441—24.1(225C) for life situations with the member's family and in the community.

(6) Developing medication management skills.

(7) Developing personal hygiene and grooming skills that contribute to the member's positive self-image.

(8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager's plan.

(2) The annual amount available for transportation and therapeutic resources must be listed in the member's service plan.

(3) The member's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member's family or legal guardian.

(4) The member's Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) Covered services. Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

a. Comprehensive care management, which means:

(1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;

(2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and

(3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

b. Care coordination, which means assisting members with:

(1) Medication adherence;

(2) Chronic disease management;

(3) Appointments, referral scheduling, and reminders; and

(4) Understanding health insurance coverage.

c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:

(1) Supporting health management;

- (2) Improving disease control; and
- (3) Enhancing safety, disease prevention, and an overall healthy lifestyle.
- d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:
 - (1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and
 - (2) Personal follow-up with the member regarding all needed follow-up after the transition.
- e. Member and family support (including authorized representatives). This support may include:
 - (1) Communicating with and advocating for the member or family for the assessment of care decisions;
 - (2) Assisting with obtaining and adhering to medications and other prescribed treatments;
 - (3) Increasing health literacy and self-management skills; and
 - (4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.
- f. Referral to community and social support services available in the community.

78.53(2) Members eligible for health home services.

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

- (1) Has at least two chronic conditions;
- (2) Has one chronic condition and is at risk of having a second chronic condition;
- (3) Has a serious mental illness; or
- (4) Has a serious emotional disturbance.

b. For purposes of this rule, the term "chronic condition" means:

- (1) A mental health disorder.
- (2) A substance use disorder.
- (3) Asthma.
- (4) Diabetes.
- (5) Heart disease.
- (6) Being overweight, as evidenced by:
 - 1. Having a body mass index (BMI) over 25 for an adult, or
 - 2. Weighing over the 85th percentile for the pediatric population.
- (7) Hypertension.

c. For purposes of this rule, the term "serious mental illness" means:

- (1) A psychotic disorder;
- (2) Schizophrenia;
- (3) Schizoaffective disorder;
- (4) Major depression;
- (5) Bipolar disorder;
- (6) Delusional disorder; or
- (7) Obsessive-compulsive disorder.

d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term "functional impairment" means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person's role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person's environment.

78.53(3) Selection of health home services provider. As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member's health home, as reported by the provider. A member must select a provider located in the member's county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

441—78.55(249A) Services rendered via telehealth. An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23).

[ARC 2166C, IAB 9/30/15, effective 11/4/15]

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

78.56(1) Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. Needs assessment. The member shall have an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment completed by a qualified trained assessor. The assessment of need shall document the member’s need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise or the member’s managed care organization has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member’s individual physical, emotional, cognitive, medical and psychosocial residuals related to the member’s brain injury and must include the following:

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

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

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

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

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

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

(7) The member’s access to transportation.

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

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

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

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

78.56(3) Covered services.

a. Service setting.

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

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

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

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

- (1) Prescriptive programming to maintain and advance progress made in rehabilitation;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Assistance in obtaining preventative, appropriate and timely medical and dental care;
- (4) Compensatory strategies to assist in managing ADLS (activities of daily living);
- (5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;
- (6) Behavioral and cognitive programming and supports;
- (7) Medication management and consultation with pharmacy;
- (8) Health and wellness management including dietary and nutritional programming;
- (9) Progressive physical strengthening, fitness and retraining;
- (10) Assistance with obtaining and use of assistive technology;
- (11) Sobriety support development;
- (12) Assistance with the self-identification of antecedent triggers;
- (13) Assistance with preparation for transition to less intensive services including accessing the community;
- (14) Flexibility in programming to meet individual needs;
- (15) Assistance with re-learning coping and compensatory strategies;
- (16) Support and assistance in seeking substance abuse and co-occurring disorders services;
- (17) Support and assistance with obtaining legal consultation and services;
- (18) Assistance with community accessibility and safety;
- (19) Assistance with re-learning household maintenance;
- (20) Assistance with recreational and leisure skill development;
- (21) Assistance with the development and application of self-advocacy skills to navigate the service system;
- (22) Opportunities to learn about brain injury and individual needs following brain injury;
- (23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;
- (24) Assistance with pursuit of education and employment goals;
- (25) Protective oversight in the residential setting and community;
- (26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;
- (27) Transitional support and training;
- (28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;
- (29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

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

- (1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;
- (2) Modifying or adapting the member's environment to improve overall functioning;
- (3) Compensatory strategies to assist in managing ADLS (activities of daily living);
- (4) Behavioral supports;
- (5) Assistance with obtaining and use of assistive technology;
- (6) Assistance with the self-identification of antecedent triggers;
- (7) Flexibility in programming to meet the member's individual needs;
- (8) Assistance with re-learning coping and compensatory strategies;

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

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

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

(12) Transitional support and training;

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) The continuity of treatment;

(3) The length of stay per member;

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

(5) Gaps in service;

(6) The results achieved;

(7) Member and stakeholder satisfaction;

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

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

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

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

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

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

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

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

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

[ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20]

441—78.57(249A) Child care medical services. Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member's physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.57(1) Nursing services are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.57(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.57(4) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.57(5) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.57(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A

treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
 - (2) Type of service to be rendered and the treatment modalities being used.
 - (3) Frequency of the services.
 - (4) Assistance devices to be used.
 - (5) Date on which services were initiated.
 - (6) Progress of member in response to treatment.
 - (7) Medical supplies to be furnished.
 - (8) Member's medical condition as reflected by the following information, if applicable:
 1. Dates of prior hospitalization.
 2. Dates of prior surgery.
 3. Date last seen by a primary care provider.
 4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 5. Prognosis.
 6. Functional limitations.
 7. Vital signs reading.
 8. Date of last episode of acute recurrence of illness or symptoms.
 9. Medications.
 - (9) Discipline of the person providing the service.
 - (10) Certification period.
 - (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.
 - (12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.
- 78.57(7)** Nursing, personal care, and psychosocial services do not include:
- a. Services provided to members aged 21 and older.
 - b. Services that require prior authorizations that are provided without regard to the prior authorization process.
 - c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).
 - d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).
 - e. Transportation services.
 - f. Services provided to a member while the member is in institutional care.
- This rule is intended to implement Iowa Code chapter 249A.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.58(249A) Qualified Medicare beneficiary (QMB) provider services.

78.58(1) Payment. Payment will be made to QMB providers for a QMB-eligible member's coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

78.58(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicare cost sharing*” means the Medicare member's responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the

individual's Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.59(249A) Health insurance premium payment (HIPP) provider services.

78.59(1) Reimbursement. A HIPP provider may bill the department for the HIPP-eligible member's out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member's health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

78.59(2) Definitions.

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Cost sharing*” means the member's health insurance in-network responsibility for a covered service. “Cost sharing” includes coinsurance, copayments, and deductibles.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Eligible member*” means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

“*Health insurance premium payment (HIPP) program*” or “*HIPP program*” has the same meaning as provided in rule 441—75.21(249A).

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.60(249A) Crisis response services. Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24, Division II.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—78.61(249A) Subacute mental health services. Payment will be made to providers (eligible pursuant to rule 441—77.56(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

This rule is intended to implement Iowa Code section 249A.4.
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- [Filed Emergency ARC 0846C, IAB 7/24/13, effective 7/1/13]
- [Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]
- [Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]
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¹ Two ARCs

² Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

³ Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

⁴ Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

⁵ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

⁶ Two ARCs

⁷ Two ARCs

⁸ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

- ⁹ Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.
- ¹⁰ Two or more ARCs
- ¹¹ July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ¹² May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.
- ¹³ July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- ¹⁴ March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020.

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE
[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

For purposes of this chapter, "managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website at: dhs.iowa.gov/ime/providers/csrp/fee-schedule.

d. Fee for service with cost settlement. Rescinded IAB 10/10/18, effective 12/1/18.

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) "e"(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment 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 by more than 4.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) "aa" and 79.1(16) "h."

h. Indian health facilities.

(1) Indian health facilities enrolled pursuant to rule 441—77.45(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 6/30/14 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	Fee schedule in effect 7/1/19. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: \$21.11 per 15-minute unit.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	<ol style="list-style-type: none"> 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.
1. Adult day care	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Fee schedule	Effective 7/1/16, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate: Veterans Administration contract rate or \$1.47 per 15-minute unit, \$23.47 per half day, \$46.72 per full day, or \$70.06 per extended day if no Veterans Administration contract.
	For intellectual disability waiver: Fee schedule for the member’s acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17, for intellectual disability waiver: The provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute or half-day rate. If no 6/30/16 rate, \$1.96 per 15-minute unit or \$31.27 per half day. For daily services, the fee schedule rate published on the department’s website, pursuant to 79.1(1)“c,” for the member’s acuity tier, determined pursuant to 79.1(30).
2. Emergency response system: Personal response system	Fee schedule	Effective 7/1/13, provider’s rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Portable locator system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: \$323.26. Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%. For intellectual disability waiver effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.20 per 15-minute unit.
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$87.99 per visit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Adult day care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Foster group care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.05 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: \$1,061.11 lifetime maximum. For intellectual disability waiver effective 7/1/13: \$5,305.53 lifetime maximum. For brain injury, health and disability, and physical disability waivers effective 7/1/13: \$6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.76 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: \$115.62 per unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
14. Senior companion	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$1.89 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/16, \$3.58 per 15-minute unit, not to exceed \$83.36 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.45 per 15-minute unit.
Group	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/18.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For brain injury waiver effective 7/1/16: \$9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For intellectual disability waiver effective 7/1/17: \$9.28 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/16. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$11.45 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/16.
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	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3.927%.
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: The fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.51 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$24.85 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$16.07 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	\$26.08 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule. See 79.1(24) "d"	Fee schedule in effect 7/1/18.
2. Home-based habilitation	See 79.1(24) "d"	Effective 7/1/13: \$11.68 per 15-minute unit, not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	See 79.1(24) "d"	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect May 4, 2016.
5. Supported employment: Individual supported employment	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Long-term job coaching	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect May 4, 2016. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11)“r.”	Effective 7/1/18: Medicare LUPA rates in effect on 6/30/18 plus a 3% increase.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)“d”)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)“g” and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)“c”	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1)“h” 2. Fee schedule for service provided for all other Medicaid members.	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare). 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities:		
1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“1” and (2)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of 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.	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.
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	See subrules 441—81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(3) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	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.	
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)“a”	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule. See 79.1(7)“d”	Fee schedule in effect 7/1/17. See 79.1(7)“d.”
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7)“c”	Rate provided by 79.1(7)“c”
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18.
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18.

79.1(3) Ambulatory surgical centers.

a. Payment is made for facility services on a fee schedule determined by the department and published on the department’s website. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)“c”). This payment is made directly to the physician or dentist.

79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers. Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)“n.”

79.1(5) Reimbursement for hospitals.

a. Definitions.

“*Adolescent*” shall mean a Medicaid patient 17 years or younger.

“*Adult*” shall mean a Medicaid patient 18 years or older.

“*Average daily rate*” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

“*Base year cost report*” means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5)“x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“*Blended base amount*” shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Blended capital costs*” shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Capital costs*” shall mean an add-on to the blended base amount, which shall compensate for Medicaid’s portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital’s base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Case-mix adjusted*” shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Case-mix index*” shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Children’s hospitals*” shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children’s hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and

2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5) "f," so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5) "y"(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's

reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

“Full DRG transfer” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

“Indirect medical education rate” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Inlier” shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

“Long stay outlier” shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)“f.”

“Low-income utilization rate” shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Medicaid inpatient utilization rate” shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Neonatal intensive care unit” shall mean a designated level II or level III neonatal unit.

“Net discharges” shall mean total discharges minus transfers and short stay outliers.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“Rate table listing” shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

“Rebasing” shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

“Rebasing implementation year” means 2008 and every three years thereafter.

“Recalibration” shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

“Short stay day outlier” shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*“f.”*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*“r.”* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*“r.”* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(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 \$75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5) "r," and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5) "r," which are paid per diem, as specified in paragraph 79.1(5) "i."

i. Payment for certified physical rehabilitation hospitals and units 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 79.1(5) "y," for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5) "y."

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph "f."

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)“b”(1), a neonatal intensive care unit under subparagraph 79.1(5)“b”(2), a psychiatric unit under paragraph 79.1(5)“i,” or a physical rehabilitation hospital or unit under paragraph 79.1(5)“i” shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if the unit’s program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)“b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations

set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5) “i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5) “i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider’s customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital’s fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state’s fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) “y,” payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. *Non-state-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. *Rate adjustments for hospital mergers.* When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.

- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5) "u" or 79.1(5) "v" cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audit and rate setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)"a" to "z" are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)"a" to "z." Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)"k."

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)"j," payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) Qualifying criteria. A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)“y” and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) Source of nonfederal share. The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) Amount of payment. The total amount of disproportionate share payments made pursuant to paragraph 79.1(5)“y” and the rural hospital disproportionate share payments shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician’s Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician’s Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)“e” for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7)“a” shall be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting, as opposed to the physician’s office. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following (consistent with “POS” definitions under Medicare, per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, revised as of May 2017):

- (1) Telehealth (POS 02).
- (2) Outpatient hospital-off campus (POS 19).
- (3) Inpatient hospital (POS 21).
- (4) Outpatient hospital-on campus (POS 22).
- (5) Emergency room-hospital (POS 23).
- (6) Ambulatory surgical center (POS 24).
- (7) Military treatment center (POS 26).
- (8) Skilled nursing facility (POS 31).
- (9) Hospice-for inpatient care (POS 34).
- (10) Ambulance-land (POS 41).
- (11) Ambulance-air or water (POS 42).
- (12) Inpatient psychiatric facility (POS 51).
- (13) Psychiatric facility-partial hospitalization (POS 52).
- (14) Community mental health center (POS 53).
- (15) Psychiatric residential treatment center (POS 56).

(16) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7)“c”). Primary care services furnished January 1, 2015, through June 30, 2017, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7)“c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)“c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)“c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

d. Payment for anesthesia services. Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)“c.” Anesthesia procedures listed in the fee schedule with a factor code of “F” are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee schedule with a factor code of “A” are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. Beginning July 1, 2017, the Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount. For 2017, that amount is \$1.40, which will be updated annually on January 1.

79.1(8) Drugs.

a. Except as provided below in paragraphs 79.1(8)“d” through “i,” all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)“c”; or

4. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee; or

3. Providers’ usual and customary charge to the general public.

b. For purposes of this subrule, average state AAC is defined as retail pharmacies' average prices paid to acquire drug products. Average state AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department's discretion. The average state AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department shall be published on the Iowa Medicaid enterprise website. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average state AAC.

c. Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries. The survey shall be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90 percent consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program, consistent with the Iowa board of pharmacy's rules on return of drugs.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8)"*a*" above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

2. The average state AAC determined pursuant to paragraph 79.1(8)"*b*" plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)"*a*"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8)"*a*" because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8)"*a*" above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

(2) The average state AAC determined pursuant to paragraph 79.1(8)"*b*" plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)"*a*"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)"*c*";

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)“a” above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug’s “best price” pursuant to 42 CFR 447.508 will be the lowest of:

(1) The provider’s actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

(2) The average state AAC determined pursuant to paragraph 79.1(8)“b” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers’ usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.45(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.45(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)“a” through “f.” The pharmacy encounter rate is the current “outpatient per visit rate (excluding Medicare)” approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Vaccines for Children Program. All providers administering vaccines 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. Providers may receive Medicaid reimbursement for the administration of vaccines to Medicaid members through the otherwise applicable reimbursement for inpatient or outpatient services.

j. Physician-administered drugs. Notwithstanding paragraphs 79.1(8)“a” through “f,” payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to the physician payment policy under subrule 79.1(2).

k. Under this subrule, no payment shall be made for sales tax.

l. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

79.1(9) *HCBS consumer choices financial management.* Rescinded IAB 5/8/19, effective 7/1/19.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person’s services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent’s compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) Prohibition against factoring. Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) Reasonable charges for services, supplies, and equipment. For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the Part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) Copayment by member. A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment of \$1 for each covered prescription or refill of any covered drug.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

- i.* Copayment charges are not applicable to services furnished pregnant women.
- j.* All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.
- k.* Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:
 - (1) Placing the patient's health in serious jeopardy,
 - (2) Serious impairment to bodily functions, or
 - (3) Serious dysfunction of any bodily organ or part.
- l.* Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.
- m.* No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.
- n.* The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13) "k." This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) Reimbursement for hospice services.

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect

the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) HCBS retrospectively limited prospective rates. This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

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 in the brain injury waiver.

(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.

(9) The reasonable costs of direct care staff training shall be treated as direct care costs, rather than as indirect administrative costs.

c. Prospective rates for new providers.

(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.

(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. Rescinded IAB 5/1/13, effective 7/1/13.

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 provided from July 1, 2015, through June 30, 2016, revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) For services provided from July 1, 2015, through June 30, 2016, providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

(4) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(5) For services provided on or after July 1, 2016, providers who do not reimburse revenues exceeding 105.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 105.5 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.

“*Medicaid claim set*” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“*Modifier*” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“*Multiple significant procedure discounting*” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“*Observation services*” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“*Outpatient hospital services*” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“*Outpatient prospective payment system*” or “*OPPS*” means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“*Outpatient visit*” shall mean those hospital-based outpatient services which are billed on a single claim form.

“*Packaged service*” means a service that is secondary to other services but is considered an integral part of another service.

“*Pass-through*” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“*Quality improvement organization*” or “*QIO*” shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rebasing*” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16) "e."

2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.

3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The 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>

Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: <ul style="list-style-type: none"> ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	Paid under OPPS APC. <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	Paid under OPPS APC. <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	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital’s total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital’s total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital’s base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.
2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.
3. The total calculated Medicaid cost for ambulance services for all hospitals.
4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital’s cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

- (1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

- (2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

- (3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

- (1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

- (2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

- (3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

- (4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

- (1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

- (2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

- (1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

- (2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. 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—subparagraph 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. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. 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 hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) Reimbursement for home- and community-based services home and vehicle modification and equipment. Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) Pharmaceutical case management services reimbursement. Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) Reimbursement for translation and interpretation services. Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) Dentists. The dental fee schedule is based on the definitions of dental and surgical procedures given in the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association.

79.1(21) Rehabilitation agencies. Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) Medicare crossover claims. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for Medicare crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicaid-allowed amount*” means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“*Medicare-allowed amount*” means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare cost sharing*” means the Medicare member's responsibility to pay for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Medicare crossover claim*” means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“*Medicare deductible and coinsurance amounts*” means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare provider reimbursement*” means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

“*Third-party payment*” means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. Reimbursement of Medicare crossover claims. Covered Medicare crossover claims shall be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider’s financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider’s Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for all home- and community-based habilitation services provided on or after January 1, 2016, shall be as provided in paragraph 79.1(24) "d." All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

b. Submission of cost reports. For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise or the Iowa Plan for Behavioral Health contractor shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24) "b"(4) but for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

d. Reimbursement for services provided on or after January 1, 2016.

(1) For dates of services on or after January 1, 2016, habilitation services, except for case management, shall be reimbursed by fee schedule. Case management will continue to be reimbursed by retrospective cost settlement.

(2) For dates of services on or after July 1, 2018, case management services shall be reimbursed by fee schedule.

79.1(25) Reimbursement for community mental health centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).

a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3). Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

b. Reimbursement methodology for community mental health centers. Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

c. Cost-based reimbursement. For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

d. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

79.1(26) Home health services.

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension xls or xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27) "b"(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

2. The reduced rate(s) shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

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

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

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

79.1(29) *Reimbursement for health insurance premium payment (HIPP) program providers.* Reimbursement for HIPP program providers shall be provided only when such provider is enrolled with Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

a. Definitions. For purposes of this subrule:

"*Coinsurance*" means a percentage of costs of a covered health care service that has to be paid.

"*Copayment*" means a fixed amount a member pays for a covered health care service.

"*Deductible*" means the amount paid for covered health care services before the insurance plan starts to pay.

"*Eligible member*" means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

"*Health insurance premium payment (HIPP) program*" or "*HIPP program*" has the same meaning as provided in rule 441—75.21(249A).

b. Claim submission. To submit a claim for reimbursement, a HIPP provider shall use Form 470-5475, Health Insurance Premium Payment (HIPP) Provider Invoice.

(1) Payment shall be made to eligible providers for a HIPP-eligible member's coinsurance, copayment, and deductible, when the HIPP-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

79.1(30) *Tiered rates.* For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1) "*c*" provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment. The SIS assessment tool and scoring criteria are available on request from the Iowa Medicaid enterprise, bureau of long-term care.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

c. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

d. For this purpose, the "SIS activities score" is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

e. Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30) "*f*" and "*g*," are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

f. Subject to adjustment pursuant to paragraph 79.1(30) "*g*," acuity tiers are the highest applicable tier pursuant to the following:

- (1) Tier 1: SIS activities score of 0 – 25.
- (2) Tier 2: SIS activities score of 26 – 40.
- (3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.
- (4) Tier 4: SIS activities score of 45 or higher.
- (5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.
- (6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.
- (7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.
- (8) RBSCCL tier: Members residing in a residential-based supported community living (RBSCCL) facility.
- (9) Enhanced tier: An individual member rate negotiated between the department and the provider.
 - g. The tier determined pursuant to paragraph 79.1(30)“f” shall be adjusted as follows:
 - (1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30)“e”(1), but with a response of “extensive support needed” (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30)“e”(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30)“f,” the tier is increased by two tiers.
 - (4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.
 - h. Tier redetermination. A member’s acuity tier may be changed in the following circumstances:
 - (1) There is a change in the member’s SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).
 - (2) A completed DHS Form 470-5486, Emergency Needs Assessment, indicates a change in the member’s support needs. A member’s case manager may request an emergency needs assessment when a significant change in the member’s needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member’s acuity tier.
 - i. New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers,

or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1)“c.”

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

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09; **ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 8206B**, IAB 10/7/09, effective 11/11/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8647B**, IAB 4/7/10, effective 3/11/10; **ARC 8649B**, IAB 4/7/10, effective 3/11/10; **ARC 8894B**, IAB 6/30/10, effective 7/1/10; **ARC 8899B**, IAB 6/30/10, effective 7/1/10; **ARC 9046B**, IAB 9/8/10, effective 8/12/10; **ARC 9127B**, IAB 10/6/10, effective 11/10/10; **ARC 9134B**, IAB 10/6/10, effective 10/1/10; **ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9176B**, IAB 11/3/10, effective 12/8/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 9706B**, IAB 9/7/11, effective 8/17/11; **ARC 9708B**, IAB 9/7/11, effective 8/17/11; **ARC 9710B**, IAB 9/7/11, effective 8/17/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9712B**, IAB 9/7/11, effective 9/1/11; **ARC 9714B**, IAB 9/7/11, effective 9/1/11; **ARC 9719B**, IAB 9/7/11, effective 9/1/11; **ARC 9722B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 9886B**, IAB 11/30/11, effective 1/4/12; **ARC 9887B**, IAB 11/30/11, effective 1/4/12; **ARC 9958B**, IAB 1/11/12, effective 2/15/12; **ARC 9959B**, IAB 1/11/12, effective 2/15/12; **ARC 9960B**, IAB 1/11/12, effective 2/15/12; **ARC 9996B**, IAB 2/8/12, effective 1/19/12; **ARC 0028C**, IAB 3/7/12, effective 4/11/12; **ARC 0029C**, IAB 3/7/12, effective 4/11/12; **ARC 9959B** nullified (See nullification note at end of chapter); **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0196C**, IAB 7/11/12, effective 7/1/12; **ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0358C**, IAB 10/3/12, effective 11/7/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0355C**, IAB 10/3/12, effective 12/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0360C**, IAB 10/3/12, effective 12/1/12; **ARC 0485C**, IAB 12/12/12, effective 2/1/13; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0581C**, IAB 2/6/13, effective 4/1/13; **ARC 0585C**, IAB 2/6/13, effective 1/9/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0708C**, IAB 5/1/13, effective 7/1/13; **ARC 0710C**, IAB 5/1/13, effective 7/1/13; **ARC 0713C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 0838C**, IAB 7/24/13, effective 7/1/13; **ARC 0840C**, IAB 7/24/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 0864C**, IAB 7/24/13, effective 7/1/13; **ARC 0994C**, IAB 9/4/13, effective 11/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1057C**, IAB 10/2/13, effective 11/6/13; **ARC 1058C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1150C**, IAB 10/30/13, effective 1/1/14; **ARC 1152C**, IAB 10/30/13, effective 1/1/14; **ARC 1154C**, IAB 10/30/13, effective 1/1/14; **ARC 1481C**, IAB 6/11/14, effective 8/1/14; **ARC 1519C**, IAB 7/9/14, effective 7/1/14; **ARC 1521C**, IAB 7/9/14, effective 7/1/14; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 1608C**, IAB 9/3/14, effective 10/8/14; **ARC 1609C**, IAB 9/3/14, effective 10/8/14; **ARC 1699C**, IAB 10/29/14, effective 1/1/15; **ARC 1697C**, IAB 10/29/14, effective 1/1/15; **ARC 1977C**, IAB 4/29/15, effective 7/1/15; **ARC 2026C**, IAB 6/10/15, effective 8/1/15; **ARC 2075C**, IAB 8/5/15, effective 7/15/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2167C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2341C**, IAB 1/6/16, effective 2/10/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2846C**, IAB 12/7/16, effective 11/15/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2930C**, IAB 2/1/17, effective 4/1/17; **ARC 2932C**, IAB 2/1/17, effective 3/8/17; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3158C**, IAB 7/5/17, effective 7/1/17; **ARC 3161C**, IAB 7/5/17, effective 7/1/17; **ARC 3162C**, IAB 7/5/17, effective 7/1/17; **ARC 3160C**, IAB 7/5/17, effective 7/1/17; **ARC 3159C**, IAB 7/5/17, effective 7/1/17; **ARC 3294C**, IAB 8/30/17, effective 10/4/17; **ARC 3295C**, IAB 8/30/17, effective 10/4/17; **ARC 3296C**, IAB 8/30/17, effective 10/4/17; **ARC 3292C**, IAB 8/30/17, effective 10/4/17; **ARC 3293C**, IAB 8/30/17, effective 10/4/17; **ARC 3481C**, IAB 12/6/17, effective 12/1/17; **ARC 3494C**, IAB 12/6/17, effective 1/10/18; **ARC 3551C**, IAB 1/3/18, effective 2/7/18; **ARC 3716C**, IAB 3/28/18, effective 5/2/18; **ARC 3790C**, IAB 5/9/18, effective 6/13/18; **ARC 4067C**, IAB 10/10/18, effective 11/14/18; **ARC 4065C**, IAB 10/10/18, effective 12/1/18; **ARC 4066C**, IAB 10/10/18, effective 12/1/18; **ARC 4068C**, IAB 10/10/18, effective 12/1/18; **ARC 4430C**, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; **ARC 4899C**, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; **ARC 4974C**, IAB 3/11/20, effective 4/15/20]

441—79.2(249A) Sanctions.

79.2(1) Definitions.

“*Affiliates*” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

“*Iowa Medicaid enterprise*” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

“*Person*” means any individual human being or any company, firm, association, corporation, institution, or other legal entity. “*Person*” includes but is not limited to a provider and any affiliate of a provider.

“*Probation*” means a specified period of conditional participation in the medical assistance program.

“*Provider*” means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

“*Suspension from participation*” means an exclusion from participation for a specified period of time.

“*Suspension of payments*” means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

“Termination from participation” means a permanent exclusion from participation in the medical assistance program.

“Withholding of payments” means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) Grounds for sanctions. The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department’s authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals’ Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, “quality services” means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department’s representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

- p.* Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.
- q.* Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.
- r.* Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.
- s.* Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.
- t.* Violation of a condition of probation, suspension of payments, or other sanction.
- u.* Loss, restriction, or lack of hospital privileges for cause.
- v.* Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.
- w.* Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.
- x.* Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.
- y.* Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) Sanctions.

- a.* The department may impose any of the following sanctions on any person:
 - (1) A term of probation for participation in the medical assistance program.
 - (2) Termination from participation in the medical assistance program.
 - (3) Suspension from participation in the medical assistance program.
 - (4) Suspension of payments in whole or in part.
 - (5) Prior authorization of services.
 - (6) Review of claims prior to payment.
- b.* The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.
- c.* Mandatory suspensions and terminations.
 - (1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.
 - (2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.
 - (3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.
 - (4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

79.2(4) Imposition and extent of sanction. The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

- a.* Seriousness of the offense.

- b. Extent of violations.
- c. History of prior violations.
- d. Prior imposition of sanctions.
- e. Prior provision of provider education (technical assistance).
- f. Provider willingness to obey program rules.
- g. Whether a lesser sanction will be sufficient to remedy the problem.
- h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5) Scope of sanction.

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) Notice to third parties. When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

79.2(7) Notice of violation.

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5) "c."

79.2(8) Suspension or withholding of payments. The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) Civil monetary penalties and interest. Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10) Report and return of identified overpayment.

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.
- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.
- (12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- (13) A refund in the amount of the overpayment.

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

[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 4973C, IAB 3/11/20, effective 4/15/20]

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

79.3(1) Financial (fiscal) records.

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

- (1) Support the determination of the provider's reimbursement rate under the medical assistance program; and
- (2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

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

79.3(2) Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

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

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

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

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

c. Components.

- (1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the

medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) "d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Service documentation shall include narrative documentation and may also include documentation in checkbox format. The service record shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5) "c" or "d," 441—paragraph 77.33(6) "d," 441—paragraph 77.34(5) "d," 441—paragraph 77.37(15) "d," 441—paragraph 77.39(13) "e," 441—paragraph 77.39(14) "d," 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 program integrity 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.
 3. Other service documentation as applicable.
- (7) Optometrist and optician services:
 1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
 2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
 3. Prior authorization documentation.
- (8) Psychologist services:
 1. Service or office psychotherapy notes or narratives.
 2. Psychological examination report and notes.
 3. Other service documentation as applicable.
- (9) Clinic services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Prescriptions.
 5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
 3. Procedure, laboratory, or test orders and results.

4. Immunization records.
- (11) Services provided by community mental health centers:
 1. Service referral documentation.
 2. Initial evaluation.
 3. Individual treatment plan.
 4. Service or office notes or narratives.
 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
 6. Written plan for accessing emergency services.
 7. Other service documentation as applicable.
- (12) Screening center services:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Laboratory reports.
 4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Immunization records.
 5. Consent forms.
 6. Prescriptions.
 7. Medication administration records.
- (14) Maternal health center services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
 1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 2. Physician orders.
 3. Consent forms.
 4. Anesthesia records.
 5. Pathology reports.
 6. Laboratory and X-ray reports.
- (17) Hospital services:
 1. Physician orders.
 2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 3. Progress or status notes.
 4. Diagnostic procedures, including laboratory and X-ray reports.
 5. Pathology reports.
 6. Anesthesia records.
 7. Medication administration records.
- (18) State mental hospital services:
 1. Service referral documentation.
 2. Resident assessment and initial evaluation.
 3. Individual comprehensive treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).

5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
1. Physician orders.
 2. Progress or status notes.
 3. Service notes or narratives.
 4. Procedure, laboratory, or test orders and results.
 5. Nurses' notes.
 6. Physical therapy, occupational therapy, and speech therapy notes.
 7. Medication administration records.
 8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:
1. Physician orders.
 2. Progress or status notes.
 3. Preliminary evaluation.
 4. Comprehensive functional assessment.
 5. Individual program plan.
 6. Form 470-0374, Resident Care Agreement.
 7. Program documentation.
 8. Medication administration records.
 9. Nurses' notes.
 10. Form 470-0042, Case Activity Report.
- (21) Services provided by psychiatric medical institutions for children:
1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (22) Hospice services:
1. Physician certifications for hospice care.
 2. Form 470-2618, Election of Medicaid Hospice Benefit.
 3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
1. Physician orders.
 2. Initial certification, recertifications, and treatment plans.
 3. Narratives from treatment sessions.
 4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (25) Behavioral health intervention:
1. Order for services.

2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:
1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
- (28) Services provided by independent laboratories:
1. Laboratory reports.
 2. Physician order for each laboratory test.
- (29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.
- (31) Medical supplies:
1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.
 4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
1. Notice of decision for service authorization.
 2. Service notes or narratives.
 3. Social history.
 4. Comprehensive service plan.
 5. Reassessment of member needs.
 6. Incident reports in accordance with 441—subrule 24.4(5).
 7. Other service documentation as applicable.
- (34) Early access service coordinator services:
1. Individualized family service plan (IFSP).
 2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.
 6. Invoices or receipts.

7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
8. Other service documentation as applicable.
- (36) Physical therapist services:
 1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.
- (37) Chiropractor services:
 1. Service or office notes or narratives.
 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
 1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
 2. Waiver of informed consent.
 3. Prior authorization documentation.
 4. Service or office notes or narratives.
- (39) Behavioral health services:
 1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
 4. Other service documentation as applicable.
- (40) Health home services:
 1. Comprehensive care management plan.
 2. Care coordination and health promotion plan.
 3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
 4. Documentation of member and family support (including authorized representatives).
 5. Documentation of referral to community and social support services, if relevant.
- (41) Services of public health agencies:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Results of communicable disease testing.
- (42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:
 1. Department-approved standardized neurobehavioral assessment tool.
 2. Community-based neurobehavioral treatment order.
 3. Treatment plan.
 4. Clinical records documenting diagnosis and treatment history.
 5. Progress or status notes.
 6. Service notes or narratives.
 7. Procedure, laboratory, or test orders and results.
 8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
 9. Medication administration records.
 10. Other service documentation as applicable.
- (43) Child care medical services:
 1. Plan of care.
 2. Certification and recertification.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
 5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).

6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

(44) Subacute mental health services.

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Medication administration records (residential services).

(45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.

1. Assessment.
2. Individual stabilization plan.
3. Service notes or narratives (history and physical, therapy records, discharge summary).
4. Medication administration records (residential services).

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

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

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

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; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 3358C, IAB 10/11/17, effective 10/1/17; ARC 3551C, IAB 1/3/18, effective 2/7/18; ARC 3554C, IAB 1/3/18, effective 2/7/18; ARC 3716C, IAB 3/28/18, effective 5/2/18; ARC 4751C, IAB 11/6/19, effective 12/11/19]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

“*Authorized representative,*” within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

“*Claim*” means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

“*Clinical record*” means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

“*Confidence level*” means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“*Customary and prevailing fee*” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“*Extrapolation*” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“*Fiscal record*” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“*Overpayment*” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“*Procedure code*” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“*Random sample*” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“*Underpayment*” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“*Universe*” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“*d*” to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph “*b.*”

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.

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

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

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

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

(2) Notice is not required for unannounced on-site reviews and audits.

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

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. *Additional information.* A provider that has made a reevaluation request pursuant to paragraph "a" of this subrule may submit clarifying information or supplemental documentation that was not

previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

c. Disagreement with sampling results. When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

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

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

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

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

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

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

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

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

79.7(1) Officers.

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff. The initial ballot following July 1, 2019, will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the council's first meeting.

d. The co-chairpersons shall appoint members to other committees approved by the council.

e. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director of human services.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) Membership. The membership of the council shall be as prescribed in Iowa Code section 249A.4B.

a. Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A.4B(3). Professional and business entities shall vote every year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department of human services.

(1) An initial election in SFY 2020 of five professional and business members shall be held. From this initial election of five members, three members with the most votes shall serve a three-year term and the other two members shall serve a two-year term. Once these members have served their initial term, the length of term for all following elected members shall be two years.

(2) Elections shall be organized along the following guidelines.

1. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department of human services staff.

2. The entities that receive the most votes shall serve on the council.

(3) Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

(4) If a voting entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification, the voting entity's seat will be considered vacant and will be filled as outlined in subparagraph 79.7(2) "a"(3).

b. Council membership of public representatives shall consist of five representatives, of which one must be a recipient of medical assistance. All five public representatives will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

c. A member of the hawki board, created in Iowa Code section 514I.5, selected by the members of the hawki board, shall be a member of the council. The hawki board member representative will be a nonvoting member of the council.

d. Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

(1) Partner agency and medical school representatives will be nonvoting members of the council.

(2) If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

(3) Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years.

e. The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate from their respective parties.

79.7(3) Responsibilities, duties and meetings. The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services .

a. *Recommendations.* Recommendations made by the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. *Council.* The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) Procedures.

a. A quorum shall consist of 50 percent (five persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present council members .

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) Expenses, staff support, and technical assistance. Expenses of the council, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council .

a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department shall present the annual budget for the medical assistance program for review and comment.

c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

d. The department shall maintain a current list of members on the council .

e. The department shall be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

[ARC 8263B, IAB 11/4/09, effective 12/9/09; ARC 3006C, IAB 3/29/17, effective 6/1/17; ARC 4975C, IAB 3/11/20, effective 4/15/20]

441—79.8(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures 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 must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-0829, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-0829 the attachment control number submitted on the ASC X12N 278 electronic transaction.

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

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

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

b. Decisions regarding approval or denial 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.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

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

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

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive procedures which are covered and which would be as effective.

(5) The advice of an appropriate professional consultant.

b. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

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

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 16. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

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

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 4973C, IAB 3/11/20, effective 4/15/20]

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

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

79.9(2) The services covered by Medicaid shall:

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

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

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

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

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7)“b,” medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)“a,” medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320.
[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14]

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

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

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

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

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

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

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

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

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

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

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

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

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

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

medical care through the provider or organization to comply with state law regarding advance directives as follows:

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

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

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

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

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

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

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

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

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise website. Managed care organizations and fiscal agents are exempt from completing an application.

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

b. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

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

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

f. Qualified Medicare beneficiary (QMB) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

g. Health insurance premium payment (HIPP) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by email, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

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

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3) “a”(1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3) “c.” Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

- (1) A compensation arrangement;
- (2) An ownership arrangement;
- (3) Managerial authority over any member of the affiliation;
- (4) The ability of one member of the affiliation to control or influence any other; or
- (5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that

was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider shall be notified of the decision on the provider's application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise's approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

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

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

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

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 1153C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) Policy requirements. Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)“a”;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) Reporting requirements.

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) Enforcement. Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) State elections. In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is “hospital-based” for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

(1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or

(2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

79.16(2) Eligible providers. To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,
2. A dentist,
3. A certified nurse midwife,
4. A nurse practitioner, or
5. A physician assistant practicing in a federally qualified health center or a rural health clinic

when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

(3) A children’s hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional’s patient volume enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a “pediatrician” is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation website, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration website at www.imeincentives.com. The applicant shall use the website to:

- (1) Attest to the applicant's qualifications to receive the incentive payment, and
- (2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) Payment. The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the CMS Registration and Attestation website.

a. The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration 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; ARC 9531B, IAB 6/1/11, effective 5/12/11; ARC 0824C, IAB 7/10/13, effective 9/1/13]

441—79.17(249A) 2013 reimbursement rate increases. Rescinded ARC 1056C, IAB 10/2/13, effective 11/6/13.

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- ¹ Effective date of 79.1(2) and 79.1(5) “t” delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.
- ² Two ARCs
- ³ Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.
- ⁴ Two or more ARCs
- ⁵ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.
- ⁶ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- ⁷ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁸ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁹ Two ARCs
- ¹⁰ July 1, 2009, effective date of amendments to 79.1(1) “d,” 79.1(2), and 79.1(24) “a”(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ¹¹ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) “b” (ARC 9959B, IAB 1/11/12).
- ¹² July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.
- ¹³ March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020.

CHAPTER 52
DEPENDENT ADULT ABUSE IN FACILITIES AND PROGRAMS

481—52.1(235E) Definitions. For purposes of this chapter, the following definitions apply:

“Assault of a dependent adult” means the commission of any act which is generally intended to cause pain or injury to a dependent adult, or which is generally intended to result in physical contact which would be considered by a reasonable person to be insulting or offensive or any act which is intended to place another in fear of immediate physical contact which will be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act.

“Caretaker” means a person who is a staff member of a facility or program who provides care, protection, or services to a dependent adult voluntarily, by contract, through employment, or by order of the court. For the purpose of an allegation of exploitation, if the caretaker-dependent adult relationship started when a staff member was employed in the facility, the staff member may be considered a caretaker after employment is terminated.

“Confidentiality” means the withholding of information from any manner of communication, public or private.

“Court” means the district court.

“Department” means the department of inspections and appeals.

“Dependent adult” means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for the person’s own care or protection is impaired, either temporarily or permanently.

“Dependent adult abuse” means any of the following as a result of the willful misconduct or gross negligence or reckless act or omission of a caretaker, taking into account the totality of the circumstances: physical injury, unreasonable confinement, unreasonable punishment, assault, sexual offense, sexual exploitation, exploitation, neglect, or personal degradation. “Dependent adult abuse” does not include any of the following:

1. Circumstances in which the dependent adult declines medical treatment if the dependent adult holds a belief or is an adherent of a religion whose tenets and practices call for reliance on spiritual means in place of reliance on medical treatment.
2. Circumstances in which the dependent adult’s caretaker, acting in accordance with the dependent adult’s stated or implied consent, declines medical treatment or care.
3. The withholding or withdrawing of health care from a dependent adult who is terminally ill in the opinion of a licensed physician, when the withholding or withdrawing of health care is done at the request of the dependent adult or at the request of the dependent adult’s next of kin, attorney in fact, or guardian pursuant to the applicable procedures under Iowa Code chapter 125, 144A, 144B, 222, 229, or 633.

“Exploitation” means a caretaker who knowingly obtains, uses, endeavors to obtain to use, or who misappropriates, a dependent adult’s funds, assets, medications, or property with the intent to temporarily or permanently deprive a dependent adult of the use, benefit, or possession of the funds, assets, medication, or property for the benefit of someone other than the dependent adult.

“Facility” means a health care facility as defined in Iowa Code section 135C.1 or a hospital as defined in Iowa Code section 135B.1.

“Gross negligence” means an act or omission that signifies more than ordinary inadvertence or inattention, but less than conscious indifference to consequences; and, in other words, means an extreme departure from the ordinary standard of care.

“Immediately,” for purposes of mandatory reporters’ reporting of suspected dependent adult abuse, means within 24 hours.

“Inspector” means a surveyor, monitor or investigator with the department or any department designee.

“Intimate relationship” means a significant romantic involvement between two persons that need not include sexual involvement, but does not include a casual social relationship or association in a business

or professional capacity. In determining whether persons are in an intimate relationship, the following nonexclusive list of factors may be considered:

1. The duration of the relationship,
2. The frequency of interaction,
3. Whether the relationship has been terminated, and
4. The nature of the relationship, characterized by either person's expectation of sexual or romantic involvement.

"Misappropriates" means taking unfair advantage of or wrongfully or dishonestly exercising control over property.

"Neglect of a dependent adult" means the deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or physical or mental health.

"Person" means person as defined in Iowa Code section 4.1.

"Personal degradation" means a willful act or statement by a caretaker intended to shame, degrade, humiliate, or otherwise harm the personal dignity of a dependent adult, or where the caretaker knew or reasonably should have known the act or statement would cause shame, degradation, humiliation, or harm to the personal dignity of a reasonable person. "Personal degradation" includes the taking, transmission, or display of an electronic image of a dependent adult by a caretaker, where the caretaker's actions constitute a willful act or statement intended to shame, degrade, humiliate, or otherwise harm the personal dignity of the dependent adult, or where the caretaker knew or reasonably should have known the act would cause shame, degradation, humiliation, or harm to the personal dignity of a reasonable person. "Personal degradation" does not include the taking, transmission, or display of an electronic image of a dependent adult for the purpose of reporting dependent adult abuse to law enforcement, the department, or other regulatory agency that oversees caretakers or enforces abuse or neglect provisions, or for the purpose of treatment or diagnosis or as part of an ongoing investigation. "Personal degradation" also does not include the taking, transmission, or display of an electronic image by a caretaker in accordance with the facility's or program's confidentiality policy and release of information or consent policies.

"Physical injury" means a physical injury, or injury which is at a variance with the history given of the injury, which involves a breach of skill or care or learning ordinarily exercised by a caretaker in similar circumstances. "Physical injury" includes 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, 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.

"Program" means an elder group home as defined in Iowa Code section 231B.1, an assisted living program certified under Iowa Code section 231C.3, or an adult day services program as defined in Iowa Code section 231D.1.

"Recklessly" means that a person acts or fails to act with respect to a material element of a public offense, when the person is aware of and consciously disregards a substantial and unjustifiable risk that the material element exists or will result from the act or omission. The risk must be of such a nature and degree that disregard of the risk constitutes a gross deviation from the standard conduct that a reasonable person would observe in the situation.

"Registry" means the central registry for dependent adult abuse information established in Iowa Code section 235B.5.

"Report" means a verbal or written statement, made to the department, which alleges that dependent adult abuse has occurred.

"Resident" means a resident of a health care facility as defined in Iowa Code chapter 135C, a patient in a hospital as defined in Iowa Code chapter 135B, a tenant of an assisted living program as defined in Iowa Code chapter 231C, a tenant in an elder group home as defined in Iowa Code chapter 231B, or a participant in an adult day services program as defined in Iowa Code chapter 231D.

"Sexual exploitation" means any consensual or nonconsensual sexual conduct with a dependent adult by a caretaker whether within a facility or program or at a location outside of a facility or program. "Sexual exploitation" includes but is not limited to:

1. Kissing;
2. Touching of the clothed or unclothed breast, groin, buttock, anus, pubes, or genitals;
3. A sex act as defined in Iowa Code section 702.17;
4. The transmission, display or taking of electronic images of the unclothed breast, groin, buttock, anus, pubes, or genitals of a dependent adult by a caretaker for a purpose not related to treatment, care, monitoring, assessment or diagnosis or as part of an ongoing investigation.

“Sexual exploitation” does not include touching which is part of a necessary examination, treatment, or care by a caretaker acting within the scope of the practice or employment of the caretaker; the exchange of a brief touch or hug between the dependent adult and a caretaker for the purpose of reassurance, comfort, or casual friendship; or touching between spouses or domestic partners in an intimate relationship.

“*Sexual offense*” means the commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 with or against a dependent adult.

“*Staff member*” means an individual who provides direct or indirect treatment or services to residents in a facility or program. Direct treatment or services include those provided through person-to-person contact. Indirect treatment or services include those provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance. Specifically excluded from the definition of “staff member” are individuals such as part-time volunteers, building contractors, repair workers or others who are in a facility or program for a very limited purpose, are not in the facility or program on a regular basis, or do not provide any treatment or services to the residents of the facility or program.

“*Unreasonable confinement*” means confinement that includes but is not limited to the use of restraints, either physical or chemical, for the convenience of staff. “Unreasonable confinement” does not include the use of confinement and restraints if the methods are employed in conformance with state and federal standards governing confinement and restraint or as authorized by a physician or physician extender.

“*Unreasonable punishment*” means a willful act or statement intended by the caretaker to punish, agitate, confuse, frighten, or cause emotional distress to the dependent adult. Such willful act or statement includes but is not limited to intimidating behavior, threats, harassment, deceptive acts, or false or misleading statements.

“*Willful misconduct*” means an intentional act of unreasonable character committed with disregard for a known or obvious risk that is so great as to make it highly probable that harm will follow.
[ARC 8294B, IAB 11/18/09, effective 1/1/10; ARC 3235C, IAB 8/2/17, effective 9/6/17]

481—52.2(235E) Persons who must report dependent adult abuse and the reporting procedure for those persons.

52.2(1) Persons who must report dependent adult abuse. The following persons shall report suspected dependent adult abuse in accordance with subrule 52.2(2) below.

a. A staff member. Specifically excluded from the definition of “staff member” only for purposes of the requirements set forth in this subrule are individuals who have no contact or de minimis contact with residents in a facility or program.

b. An employee of a facility or program who, in the course of employment, examines, attends, counsels, or treats a dependent adult in a facility or program and reasonably believes the dependent adult has suffered dependent adult abuse.

52.2(2) Reporting suspected dependent adult abuse in facilities or programs.

a. If a staff member or employee is required to make a report pursuant to this rule, the staff member or employee shall immediately notify the person in charge or the person’s designated agent who shall then notify the department within 24 hours of such notification or the next business day.

b. If the person in charge is the alleged dependent adult abuser, the staff member shall directly report the abuse to the department within 24 hours or the next business day.

c. Nothing in this subrule prevents a mandatory reporter or any other person from notifying the department directly of any suspected abuse.

d. The employer or supervisor of a person who is required to or may make a report pursuant to this rule shall not apply a policy, work rule, or other requirement that interferes with the person making a report of dependent adult abuse or that results in the failure of another person to make the report.

e. When the person making the report has reason to believe that immediate protection for the dependent adult is advisable, that person should also immediately make an oral report to an appropriate law enforcement agency.

f. A report of suspected dependent adult abuse shall contain as much of the following information as the person making the report is able to furnish:

- (1) The date and time of the incident;
- (2) The name, date of birth and diagnoses of the dependent adult;
- (3) Whether the dependent adult sustained an injury and, if yes, whether photographs of the injury were taken;
- (4) The nature and extent of the dependent adult abuse, including evidence of previous dependent adult abuse allegations;
- (5) A list of the staff members working at the time of the incident, including each staff member's full name, title, date of birth, address and telephone number;
- (6) The alleged perpetrator's full name, title, date of birth, social security number, address and telephone number;
- (7) Other information which the person making the report believes might be helpful in establishing the cause of the abuse or the identity of the person or persons responsible for the abuse or helpful in providing assistance to the dependent adult; and
- (8) The name, address and telephone number of the person making the report.

52.2(3) A report shall be accepted whether or not it contains all of the information requested. When the report is made to any agency other than the department, that agency shall promptly refer the report to the department.

52.2(4) A person required to report abuse who knowingly and willfully fails to do so within 24 hours may be subject to criminal penalties and civil liability as provided for by statute.

52.2(5) Interference with a person required to report.

a. It is unlawful for any person or employer to discharge, suspend, or otherwise discipline a person for any of the following:

- (1) For reporting suspected dependent adult abuse;
- (2) For cooperating with or assisting the department in evaluating or investigating a case of dependent adult abuse; or
- (3) For participating in judicial proceedings relating to dependent adult abuse.

b. A person or employer found in violation of this subrule is guilty of a simple misdemeanor.

52.2(6) Staff members who are employed by a facility or program on January 1, 2010, and who were not previously required to attend dependent adult abuse training shall be required to have attended the training no later than December 31, 2010.

[ARC 8294B, IAB 11/18/09, effective 1/1/10]

481—52.3(235E) Reports and registry of dependent adult abuse.

52.3(1) *Receipt and evaluation of reports.* The department shall receive and evaluate reports of dependent adult abuse in facilities and programs. The department shall inform the department of human services of such evaluations and dispositions for inclusion in the central registry for dependent adult abuse information pursuant to Iowa Code section 235B.5.

52.3(2) *Reports sent to the department or the department of human services.* Any person who believes that a dependent adult has suffered dependent adult abuse may report the suspected dependent adult abuse to the department. The department shall transfer any reports received of dependent adult abuse in the community to the department of human services. The department of human services shall transfer any reports received of dependent adult abuse in facilities or programs to the department.

52.3(3) *Reports of abuse that is minor, isolated, and unlikely to reoccur.*

a. Minor, isolated, and unlikely to reoccur—first instance. A report of dependent adult abuse that meets the definition of “dependent adult abuse” as defined in Iowa Code section 235E.1(5) “a”(1)(a) or (d), or section 235E.1(5) “a”(3), which the department determines is minor, isolated, and unlikely to reoccur shall be collected and maintained by the department of human services for a five-year period, shall not be included in the central registry, and shall not be considered founded dependent adult abuse.

b. Minor, isolated, and unlikely to reoccur—subsequent instance(s). A subsequent report of dependent adult abuse that meets the definition of “dependent adult abuse” as defined in Iowa Code section 235E.1(5) “a”(1)(a) or (d), or section 235E.1(5) “a”(3), that occurs within the five-year period, and that is committed by the same caretaker may also be considered minor, isolated, and unlikely to reoccur, depending on the totality of circumstances.

c. Retention of reports. All initial and subsequent reports are collected and maintained by the department of human services until a five-year period has expired, so long as no additional reports have been filed.

[ARC 8294B, IAB 11/18/09, effective 1/1/10; ARC 5004C, IAB 3/25/20, effective 4/29/20]

481—52.4(235E) Financial institution employees and reporting suspected financial exploitation. An employee of a financial institution may report suspected financial exploitation of a dependent adult to the department.

[ARC 8294B, IAB 11/18/09, effective 1/1/10]

481—52.5(235E) Evaluation of report. Upon receipt of a report as defined in rule 481—52.1(235E), the department shall conduct an intake sufficient to determine whether the allegation constitutes dependent adult abuse as defined in rule 481—52.1(235E).

[ARC 8294B, IAB 11/18/09, effective 1/1/10]

481—52.6(235E) Separation of victim and alleged abuser. Upon receiving a claim of dependent adult abuse of a dependent adult in a facility or program, the facility or program shall separate the victim and the alleged abuser immediately and shall maintain that separation until the department’s abuse investigation is completed and the abuse determination is made.

NOTE: Facilities that participate in the federal Medicare or Medicaid program may be subject to additional federal requirements regarding separation.

[ARC 8294B, IAB 11/18/09, effective 1/1/10]

481—52.7(235E) Interviews, examination of evidence, and investigation of dependent adult abuse allegations.

52.7(1) Entering and examining evidence at a facility or program. An inspector of the department may enter any facility or program without a warrant and may examine all records and items pertaining to residents, employees, former employees, and the alleged dependent adult abuser and any other records and items necessary to ensure the integrity of the investigation unless the record or item is protected by some other legal privilege.

52.7(2) Interviews.

a. An inspector of the department may contact or interview any resident, employee, former employee, or any other person who might have knowledge about the alleged dependent adult abuse.

b. An alleged dependent adult abuser may request to have an attorney present at the alleged dependent adult abuser’s expense at any time during the interview, but the request may not unreasonably delay the investigation. An employee organization representative or union representative may observe an investigative interview conducted by the department of an alleged dependent adult abuser if all of the following conditions are met:

(1) The alleged dependent adult abuser is part of a bargaining unit or employee organization that is party to a collective bargaining agreement under Iowa Code chapter 20 or any other applicable state or federal law.

(2) The alleged dependent adult abuser requests the presence of a union representative or employee organization representative.

(3) The representative maintains the confidentiality of all information from the interview subject to the penalties provided in Iowa Code section 235B.12 if such confidentiality is breached.

(4) The purpose of the interview is a civil administrative dependent adult abuse investigation under applicable law.

52.7(3) *Photographs of victim, vicinity and related matters.* An inspector may take or cause to be taken photographs of the dependent adult abuse victim and the vicinity involved. The department shall obtain consent from the dependent adult abuse victim or guardian or other person with a power of attorney over the dependent adult abuse victim prior to taking photographs of the dependent adult abuse victim.

52.7(4) *Evaluating information.* An inspector shall consider the information as reported, other known or discovered information, and any information gathered as a result of the inspector's contact with collateral sources, including prior abuse allegations and disciplinary actions.

[ARC 8294B, IAB 11/18/09, effective 1/1/10]

481—52.8(235E) Notification to subsequent employers. The department shall notify a facility or program that subsequently employs an alleged or founded dependent adult abuser.

[ARC 8294B, IAB 11/18/09, effective 1/1/10]

These rules are intended to implement Iowa Code chapter 235E.

[Filed ARC 8294B (Notice ARC 7828B, IAB 6/3/09; Amended Notice ARC 7939B, IAB 7/1/09), IAB 11/18/09, effective 1/1/10]

[Filed ARC 3235C (Notice ARC 3110C, IAB 6/7/17), IAB 8/2/17, effective 9/6/17]

[Filed ARC 5004C (Notice ARC 4890C, IAB 1/29/20), IAB 3/25/20, effective 4/29/20]

LAW ENFORCEMENT ACADEMY[501]

[Prior to 1971 IDR, see Dept. of Public Safety]
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CHAPTER 1
ORGANIZATION AND ADMINISTRATION

[Appeared as rules 3.1, 4.1, 5.1 and ch 6 prior to 4/10/85]

[Prior to 3/11/87, Law Enforcement Academy[550] Ch 1]

501—1.1(80B) Definitions. In regards to the definitions as used in the rules of the law enforcement academy the following definitions apply, unless the context otherwise requires:

“*Academy*” refers to the Iowa law enforcement academy.

“*Academy council*” means the Iowa law enforcement academy council.

“*Act*” means the Iowa Administrative Procedure Act.

“*Applicant*” means all individuals seeking an entry level position as a law enforcement officer. This shall not include individuals who are being promoted within a department.

“*Certificate*” means the document issued to a law enforcement officer when documentation has established compliance with the minimum hiring standards and successful completion of the training requirements.

“*Certification*” means the issuing of a certificate to a law enforcement officer upon documentation that the officer has been employed and trained in compliance with the established minimum standards.

“*Contested case*” means a proceeding in which the legal rights of a party to continue to be certified as a law enforcement officer in the state of Iowa are determined by the council or its designee after an opportunity for an evidentiary hearing.

“*Convicted*” or “*conviction*” means a finding of guilt, a plea of guilty, a deferred judgment, a deferred or suspended sentence, and an adjudication of delinquency as a juvenile.

“*Council*” refers to the Iowa law enforcement academy council.

“*Director*” refers to the director of the Iowa law enforcement academy.

“*Employing agency*” means any state, county, or municipal government or governmental body that employs law enforcement officers.

“*Facilities approval application form*” means the form prepared by the Iowa law enforcement academy council to be utilized in an application for approval of a regional law enforcement training facility.

“*Facility*” means a jail as defined in 201—Chapter 50 or a temporary holding facility as defined in 201—Chapter 51.

“*Felony*” means a criminal offense classified as a felony in the jurisdiction in which it was committed.

“*Final selection process*” means that process by which the final applicant for a law enforcement position is selected. This process requires, minimally, that the person to be hired shall have successfully completed the mandated psychological testing.

“*General jailer instructors*” will be those instructing in subjects clearly related to the operation of a jail.

“*Good cause*” means termination of employment for any of the following reasons:

1. *Gross negligence*: Where the officer’s act or failure to act creates a danger or risk to persons, property, or to the efficient operation of the department, recognizable as a gross deviation from the standard of care that a reasonable officer would observe in a similar circumstance.

2. *Insubordination*: A refusal by an employee to comply with a rule or order where the rule or order was reasonably related to the orderly, efficient, or safe operation of the employer’s business and where the employee’s refusal to comply with the rule or order constitutes breach of duties.

3. *Incompetence or gross misconduct*: In determining what constitutes “incompetence or gross misconduct,” the council may take into account sources as practices generally followed in the profession, current teaching at law enforcement training facilities and technical reports and literature relevant to the field of law enforcement.

“*Guest lecturer*” is a person who, by reason of position or experience, can make a worthwhile contribution to a training program. The instructor will normally be experienced in a specialized area and the instruction limited to the area of the instructor’s experience. While the regional training facility

may avail themselves of the instructor's services on repeated occasions, the use will not be of such frequency as to reasonably infer the instructor is a member of the permanent regional instructional staff.

"Initial certification" means the law enforcement certification granted to a law enforcement officer by the Iowa law enforcement academy council pursuant to 501—3.1(80B), 3.8(80B), or 3.9(80B), Iowa Administrative Code.

"Iowa law enforcement emergency care provider" or *"ILEECP"* means an individual who is certified by the academy as an Iowa peace officer, who has successfully completed an emergency medical care provider curriculum approved by the academy, and who is currently certified by the academy as an emergency medical care provider.

"Jail" means any place administered by the county sheriff and designed to hold inmates for as long as lawfully required but not to exceed one year pursuant to Iowa Code chapters 356 and 356A.

"Jail administrator" means the sheriff, sheriff's designee, or the executive head of any agency operating a jail.

"Jailer" means any person involved in the booking or supervision of inmates or detainees and meeting the requirements of rules 201—50.10(356,356A) and 50.11(356,356A) or 201—51.8(356,356A) and 51.9(356,356A).

"Jailer training program" means a jailer in-service or basic training program.

"Law enforcement experience" means experience gained by a law enforcement officer whose primary job function is the enforcement of criminal laws and the prevention and detection of crime.

"Law enforcement officer" means an officer appointed by the director of the department of natural resources; an officer appointed by the director of the Iowa law enforcement academy and sworn in for the purposes of training; a member of a police force or other agency or department of the state, county, or city regularly employed as such and who is responsible for the prevention and detection of crime and the enforcement of the criminal laws of this state; and all individuals, as determined by the council, who by the nature of their duties may be required to perform the duties of a peace officer.

"Nonstate agency" means all other agencies that are not state agencies.

"Party" means each person or agency named or admitted as a party properly seeking and entitled as of right to be admitted as a party.

"Person" means any individual, corporation or association covered by the Act other than an agency.

"Pleadings" means a protest, motion, answer, reply or other document filed in a contested case proceeding.

"Presiding officer" means an administrative law judge employed by the Iowa department of inspections and appeals or the full council or a three-member panel of the council.

"Professional jailer instructors" will be those instructing subjects in the area of the law, human relations, medicine, and other areas requiring specialized academic training or experience. Final decision as to whether an instructor is in the general or professional area rests with the academy.

"Proposed decision" means the presiding officer's recommended findings of fact, conclusions of law, decision, and order in a contested case in which the full council did not preside.

"Recognized expert" is a person who, by reason of position or experience, can make a worthwhile contribution to a training program. Normally the recognized expert will be experienced in a specialized area and instruction will be limited to the area of experience. (See subrule 9.2(2))

"Recommendation" means a request by an employing agency asking the council to revoke the certification of a past or present law enforcement officer.

"Regional facility director" means the administrative head or responsible official of the approved regional law enforcement training facility.

"Regional training facility" means an approved regional law enforcement training facility.

"Regular law enforcement officer" means those full-time or part-time officers who are subject to the Iowa law enforcement academy hiring, training, and certification requirements.

"Revocation" means the process by which the council withdraws an individual's certification. A person remains under revocation until the time it can be demonstrated to the council that the grounds for revocation no longer exist and the officer's certification is reinstated.

“*Salvage vehicle theft examination*” means a salvage vehicle theft examination conducted by a law enforcement officer pursuant to Iowa Code section 321.52(4)“c.”

“*Salvage vehicle theft examiner*” means a law enforcement officer certified by the Iowa law enforcement academy to conduct vehicle theft examinations pursuant to Iowa Code section 321.52(4)“c.”

“*State agency*” means any department or division of state government which derives its primary funding from the state treasury.

“*Temporary holding facility*” means secure holding rooms or cells administered by a law enforcement agency where detainees may be held for a limited period of time, not to exceed 24 hours, and a reasonable time thereafter to arrange for transportation to an appropriate facility.

“*Training program director*” means the official responsible for a jailer training program.

“*Weapon*” shall mean any firearm, striking instrument or chemical agent authorized for use as a weapon by the hiring authority.

Unless otherwise specifically stated, the terms used in these rules promulgated by the council shall have the meaning defined by this chapter.

This rule is intended to implement Iowa Code sections 80B.3, 80B.11, 80B.13, 80D.7 and 321.52. [ARC 3997C, IAB 9/12/18, effective 10/17/18; ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—1.2(80B) Council established. The council and the academy were created by an Act of the Sixty-second General Assembly, now cited as Iowa Code chapter 80B. The general purposes for which the council and academy were established are:

1. To maximize training opportunities for law enforcement officers.
2. To coordinate training and to set standards for the law enforcement service, all of which are imperative to upgrading law enforcement to a professional status.

This rule is intended to implement Iowa Code section 80B.6.

501—1.3(80B) Administration. The administration of the Act creating the council and academy is vested in the office of the governor.

This rule is intended to implement Iowa Code section 80B.5.

501—1.4(80B) Council membership. The selection, appointment, and approval of members to the council are made as provided for in Iowa Code section 80B.6.

This rule is intended to implement Iowa Code section 80B.6.

501—1.5(80B) Council officers. The council shall select from its membership a chairperson and a vice chairperson each of whom shall serve for a term of one year and who may be reelected.

This rule is intended to implement Iowa Code section 80B.7.

501—1.6(80B) Meetings. The council shall meet as least once each quarter of each year and shall hold special meetings when called by the chairperson or, in the absence of the chairperson, by the vice chairperson, or by the chairperson upon written request of six members of the council.

1.6(1) Order of business. The meetings of the council shall be presided over by the chairperson or vice chairperson. Unless otherwise stipulated in these rules, Robert’s Rules of Order are to be followed in conducting the business of the council.

1.6(2) Open meetings. All meetings are open to the public in accordance with the open meetings law, Iowa Code chapter 21. Members of the public may be recognized at the discretion of the chairperson.

1.6(3) Notice, minutes and agenda.

a. The director shall cause advance public notice of the time and place of each meeting in accordance with Iowa Code section 21.4.

b. The director shall cause minutes of all council meetings to be kept showing the time and place, the members present, and the action taken at each meeting. The minutes will constitute the official record of all actions by the council. Minutes of each meeting will be prepared and distributed to members of the council.

c. At least one week prior to the date of a regular meeting, the director shall prepare a tentative agenda for the next meeting of the council and shall cause the distribution of the tentative agenda to the council. At least one week prior to a regular meeting, a council member may submit an item to be included on the agenda. This agenda shall also list the date, time and place of the meeting.

1.6(4) Quorum and majority vote. A quorum shall consist of two-thirds of the currently appointed voting members of the council. Action of the council must be approved by a simple majority of the voting members present.

1.6(5) Information available. All records, minutes, manuals and other information pertaining to council action shall be kept at the academy. The information shall be open for inspection to the public during normal working hours.

1.6(6) Place of meetings. Meetings will normally be held at the Academy, Camp Dodge, Johnston, Iowa but may be held at a different location as determined by the council.

This rule is intended to implement Iowa Code section 80B.9.
[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—1.7(80B) Address of council. All submissions to or requests of the council shall be made through the office of the Director, Iowa Law Enforcement Academy, P.O. Box 130, Camp Dodge, Johnston, Iowa 50131.

This rule is intended to implement Iowa Code section 80B.9.

501—1.8(80B) Emergency action. In the event of an emergency requiring prompt action by the council, the director may, with the approval of the chairperson, telephonically poll members of the council concerning the needed action. The vote of each member should be recorded and the agreement of a majority of voting members shall constitute official action by the council. Such action must be ratified at the next scheduled meeting of the council and the minutes reflect the nature of the emergency.

This rule is intended to implement Iowa Code section 80B.13(2).

501—1.9(80B) Authority of council—operational standards. The authority of the council shall be as set forth in Iowa Code section 80B.13. The director shall, subject to the review of the council, promulgate operational standards relative to the operation of the academy.

This rule is intended to implement Iowa Code section 80B.13.

501—1.10(80B) Budget submitted to comptroller. The director, with the approval of the council, shall submit to the state comptroller, annually and in such form as required by Iowa Code chapter 8, estimates of its expenditure requirements. Estimates shall include the costs of administration, maintenance, and operation, and the cost of any proposed capital improvements or additional programs.

This rule is intended to implement Iowa Code section 80B.14.

501—1.11(17A,80B) Petition for rule making. Any person or agency may file a petition for rule making with the Academy Council at the Iowa Law Enforcement Academy, Camp Dodge, P.O. Box 130, Johnston, Iowa 50131-0130.

1.11(1) The petition. A petition is deemed filed when it is received by the academy. The academy must provide the petitioner with a file-stamped copy of the petition if the petitioner provides the academy with an extra copy for this purpose. The petition must be typewritten, or legibly handwritten in ink, and must substantially conform to the following form:

IOWA LAW ENFORCEMENT ACADEMY COUNCIL

Petition by (Name of Petitioner) for the (adoption, amendment or repeal) of rules relating to (state subject matter).)))))	PETITION FOR RULE MAKING
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The petition must provide the following information:

1. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.

2. A citation to any law deemed relevant to the academy council's authority to take the action urged or to the desirability of that action.

3. A brief summary of petitioner's arguments in support of the action urged in the petition.

4. A brief summary of any data supporting the action urged in the petition.

5. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the proposed action which is the subject of the petition.

6. Any request by petitioner for a meeting provided for by subrule 1.11(4).

The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

The academy council may deny a petition because it does not substantially conform to the required form.

1.11(2) Briefs. The petitioner may attach a brief to the petition in support of the action urged in the petition. The academy council or the academy staff may request a brief from the petitioner or from any other person concerning the substance of the petition.

1.11(3) Inquiries. Inquiries concerning the status of a petition for rule making may be made to the Academy Director, Iowa Law Enforcement Academy Council, Camp Dodge, P.O. Box 130, Johnston, Iowa 50131-0130.

1.11(4) Academy council consideration. Upon request by petitioner in the petition, the academy director must schedule a brief and informal meeting between the petitioner and the academy council, a member of the academy council, or a member of the staff of the academy to discuss the petition. The academy council or a member of the academy staff may request the petitioner to submit additional information or argument concerning the petition. Comments may also be solicited from any person on the substance of the petition. Also, comments on the substance of the petition may be submitted to the academy council by any person.

Within 60 days after the filing of the petition, or within any longer period agreed to by the petitioner, the academy council must, in writing, deny the petition and notify the petitioner of its action and the specific grounds for the denial, or grant the petition and notify the petitioner that it has instituted rule-making proceedings on the subject of the petition. The petitioner shall be deemed notified of the denial or grant of the petition on the date when the academy council mails or delivers the required notification to the petitioner.

Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the academy council's rejection of the petition.

This rule is intended to implement Iowa Code section 17A.7.

[Filed 5/26/78, Notice 4/19/78—published 6/14/78, effective 7/19/78]

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[Filed ARC 5006C (Notice ARC 4866C, IAB 1/15/20), IAB 3/25/20, effective 4/29/20]

CHAPTER 2
MINIMUM STANDARDS FOR IOWA LAW ENFORCEMENT OFFICERS

[Appeared as Ch 1 prior to 4/10/85]

[Prior to 3/11/87, Law Enforcement Academy[550] Ch 2]

501—2.1(80B) General requirements for law enforcement officers. In no case shall any person hereafter be selected or appointed as a law enforcement officer unless the person:

2.1(1) Is a citizen of the United States and a resident of Iowa or intends to become a resident upon being employed; provided that the state residency requirement under this subrule shall not apply to employees of a city or county that has adopted an ordinance to allow employees of the city or county to reside in another state and shall not apply to an employee of a city or county that later repeals such an ordinance if the employee resides in another state at the time of the repeal. A city or county that has adopted an ordinance to allow the employees of the city or county to reside in another state shall provide a current copy of the ordinance to the Iowa law enforcement academy. Railway special agents who are approved by the commissioner of public safety as special agents of the department shall be exempt from the Iowa residency requirement.

2.1(2) Is 18 years of age at the time of appointment.

2.1(3) Has a valid driver's or chauffeur's license issued by the state of Iowa. Railway special agents who are approved by the commissioner of public safety as special agents of the department and officers who are allowed to reside in an adjacent state shall be required to possess a valid driver's or chauffeur's license of the state of residence of the officer.

2.1(4) Is not addicted to drugs or alcohol.

2.1(5) Is of good moral character as determined by a thorough background investigation including a fingerprint search conducted on local, state and national fingerprint files and has not been convicted of a felony or a crime involving moral turpitude. "Moral turpitude" is defined as an act of baseness, vileness, or depravity in the private and social duties which a person owes to another person or to society in general, contrary to the accepted and customary rule of right and duty between person and person. Moral turpitude is conduct that is contrary to justice, honesty or good morals.

a. The following nonexclusive list of acts has been found by the Iowa law enforcement academy council to involve moral turpitude:

(1) Any felony. As used in this section, the word "felony" means any offense punishable in the jurisdiction where it occurred by imprisonment for a term exceeding one year, but does not include any offense, other than an offense involving a firearm or explosive, classified as a misdemeanor under the laws of the state and punishable by a term of imprisonment of two years or less.

(2) A misdemeanor crime of domestic violence as defined by Iowa Code section 724.26(2) "c," or other offenses of domestic violence.

(3) An adjudication of delinquency as a juvenile based on conduct that would constitute a felony if committed by an adult.

(4) Assault or harassment.

(5) Stalking.

(6) Any offense in which a weapon was used in the commission.

(7) Income tax evasion.

(8) Perjury or its subornation.

(9) Theft, aggravated theft, fraudulent practices, robbery or burglary.

(10) Any sex crime or crime listed in Iowa Code chapter 709.

(11) Conspiracy or solicitation to commit a crime listed in this rule.

(12) Defrauding the government.

(13) Delivering, manufacturing or possessing with the intent to deliver or manufacture a controlled substance.

(14) Convictions by any other state or by the federal government under statutes substantially corresponding to the crimes listed in this rule.

(15) Any crime as an adult that resulted in the requirement of being listed on a sex offender registry.

(16) An adjudication of delinquency as a juvenile based on conduct that would constitute a crime as an adult that resulted in the requirement of being listed on a sex offender registry.

b. In determining whether to grant a waiver of subrule 2.1(5) under rule 501—16.3(17A,80B), the council shall consider in its analysis of numbered paragraph “4” of rule 501—16.3(17A,80B):

- (1) The nature and seriousness of the crime;
- (2) The time elapsed since the crime was committed;
- (3) The degree of rehabilitation which has taken place since the crime was committed;
- (4) The likelihood that the person will commit the same crime again;
- (5) The number of criminal convictions; and
- (6) Such additional factors as may in a particular case demonstrate mitigating circumstances or heightened risk to public safety.

2.1(6) Has successfully passed a physical test adopted by the Iowa law enforcement academy.

2.1(7) Is not by reason of conscience or belief opposed to the use of force, when necessary to fulfill that person’s duties.

2.1(8) Is a high school graduate with a diploma, or possesses a GED equivalency certificate.

2.1(9) Has an uncorrected vision of not less than 20/100 in both eyes, corrected to 20/20. Has color vision consistent with the occupational demands of law enforcement. Passing any of the following color vision tests indicates that the applicant has color vision abilities consistent with the occupational demands of law enforcement:

Pseudoisochromatic plates tests such as but not limited to: Tokyo Medical College, Ishihara, Standard Pseudoisochromatic Plates, Dvorine, American Optical HRR Plates, American Optical.

Panel tests such as:

Farnsworth Dichotomous D-15 Test or any other test designed and documented to identify extreme anomalous trichromatic, dichromatic or monochromatic color vision.

Individuals with extreme anomalous trichromatism or monochromasy color vision, as determined through testing, are not eligible to be hired as law enforcement officers in the state of Iowa.

2.1(10) Meets hearing standards as outlined below.

a. The person shall have normal hearing in each ear. Hearing is considered normal when, tested by an audiometer, hearing sensitivity thresholds are within 25dB measured at 500Hz, 1000Hz, 2000Hz and 3000Hz averaged together.

b. If the person does not have normal hearing as described above and any of the following (as recommended by the American Academy of Otolaryngology) conditions exist, a medical specialist’s evaluation (otologic evaluation) is required in order for the candidate to be considered for hire:

- (1) Average hearing level at 500Hz, 1000Hz, 2000Hz, and 3000Hz greater than 25dB, in either ear.
- (2) Difference in average hearing level between the better and poorer ear of:
 1. More than 15dB at 500Hz, 1000Hz, and 2000Hz, or
 2. More than 30dB at 3000Hz, 4000Hz, and 6000Hz.
- (3) History of ear pain; drainage; dizziness; severe persistent tinnitus; sudden, fluctuating, or rapidly progressive hearing loss; or a feeling of fullness or discomfort in one or both ears within the preceding 12 months.
- (4) Cerumen accumulation sufficient to completely obstruct the view of the tympanic membrane or a foreign body in the ear canal.
- (5) Use of a hearing aid.

c. Functional hearing evaluation required. Issues of reversibility and prognosis should be addressed during the otologic evaluation. The evaluation should consist of directional speech comprehension in noise and speech comprehension in quiet using the High Intensity Noise Test (HINT) or other tests that meet the performance characteristics as outlined in paragraph “d.” Candidates who perform more poorly than the fifth percentile of the normal hearing group under any of the three background noise conditions (noise in front, right, or left) are not eligible for hire. Candidates with quiet thresholds greater than 28dB(A) on the HINT or other tests that meet the performance characteristics as outlined in paragraph “d” are not eligible for hire.

d. Required performance testing characteristics include the following:

- (1) Testing is available in both headphone and sound field versions.
- (2) The testing has an adequate normal hearing control group.
- (3) The testing is capable of spatial separation between the speech and the noise source.
- (4) The testing uses adaptive testing techniques.
- (5) The testing uses a stationary background noise with the same average level across frequencies as the speech.

e. Use of a hearing aid. A candidate who uses a hearing aid(s) should be administered the HINT or other tests that meet the performance characteristics as outlined in paragraph “d” to assess speech comprehension ability in noise and quiet. Both tests must be administered by sound field methods rather than headphones. An aided audiogram can be reviewed to evaluate sound detection ability.

Before functional testing, the examining physician must ensure that the aid(s) has been worn regularly for at least one month, since it takes some practice before an individual obtains the maximum benefit from the hearing aid(s). Furthermore, the examining physician should obtain all records from the audiologist who dispensed the hearing aid(s). The records must include documentation of the fitting program and other hearing aid settings, which are used on a regular basis by the candidate. This information shall be reviewed by the certified audiologist performing the testing procedure to verify that the settings have not been intentionally altered.

The following protocol must be used. No modifications to the candidate’s hearing aid program or settings should be made prior to or during the performance of this protocol.

(1) Evaluate whether the hearing aid(s) is working properly. The electroacoustic response characteristics of each hearing aid worn by the candidate should be measured in an appropriate acoustic coupler and test chamber according to ANSI specifications (ANSI 1992 and 1996). The response of the hearing aid(s) should be measured at the four designated input levels with a broadband test signal, as specified in the specifications. All measurements should be printed and retained in the candidate’s records. If the hearing aid(s) is not in proper working condition, no further testing should be performed at that time. The candidate may elect to have the hearing aid(s) repaired or replaced and may return to repeat the protocol. In this event, the entire protocol, including measurements of the electroacoustic response characteristics of the hearing aid(s), should be repeated with the new or repaired hearing aid(s). Hearing aid sales, repairs, and replacements should be from an independent provider other than the provider of the functional assessment services.

(2) Review the candidate’s regular fitting program and settings. The fitting program and settings should be equivalent to those measured according to subparagraph (1). If they are not equivalent, no further testing should be performed at that time.

(3) Determine whether the functional gain is both physiologic and appropriate for the candidate’s hearing loss. Unaided and aided binaural sound field thresholds should be measured at 250Hz, 500Hz, 1000Hz, 2000Hz, 3000Hz, 4000Hz, and 6000Hz, using warble tone stimuli presented from a loudspeaker positioned 1 meter in front of the candidate at 0 degrees azimuth. If the functional gain is not physiologic and appropriate, then no further testing should be performed at that time.

(4) Perform aided sound field HINT or other approved testing in noise and quiet. Compare the results to the site-specific normal values for sound field noise front, noise right, and noise left conditions. If the measured thresholds are better than the fifth percentile under all three conditions, then the noise testing shall be repeated with the background noise fixed at 80dB(A). The same normative values used with the standard background noise levels may be used to assign percentile scores to these results.

The examining physician may use the evaluation algorithm described in Hearing Guidelines—Abnormal Audiogram, with one exception. Many present-day hearing aids employ methods of sound processing that vary as a function of the background noise level, and it is necessary to measure aided sound field HINT thresholds through a range of background noise levels. Therefore, candidates who use hearing aid(s) should be functionally normal both under standard HINT background noise levels (i.e., 65dB) and at levels that are commonly encountered in the field (80dB).

The candidate has met the required hiring standards if the candidate has demonstrated acceptable functional ability when wearing a hearing aid(s) and wears a hearing aid(s) when assigned to field duty.

2.1(11) Is examined by a licensed physician or surgeon and meets the physical requirements necessary to fulfill the responsibilities of a law enforcement officer.

[ARC 2960C, IAB 3/1/17, effective 4/5/17; ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—2.2(80B) Mandatory psychological testing and administrative procedures. In no case shall any person be selected or appointed as a law enforcement officer unless that person has performed satisfactorily in preemployment cognitive or personality tests, or both, prescribed by the Iowa law enforcement academy.

2.2(1) Required cognitive test.

a. Entry-level applicants for all law enforcement positions in the state of Iowa shall take the Stanard & Associates' National Police Officer Selection Test (POST).

b. The minimum satisfactory score to be eligible for employment is 70 percent on each of the four sections of this examination. Agencies and civil service commissions may require a higher satisfactory score than 70 percent on each or any of the sections of the test.

2.2(2) Required personality test.

a. The Minnesota Multiphasic Personality Inventory 2 (MMPI-2) test shall be taken by all applicants in the final selection process for a law enforcement position.

b. The prescribed personality test for an applicant in the final selection process shall be administered, scored and interpreted by the academy or by an individual who has been approved by the academy. The prescribed personality test for an applicant in the final selection process shall be evaluated by the Iowa law enforcement academy. These tests shall be evaluated and test results and evaluations shall be forwarded to a law enforcement agency for selection purposes only by the Iowa law enforcement academy upon proper waiver by the applicant.

2.2(3) Test administration.

a. Test results may be forwarded by the academy to a law enforcement agency for selection purposes only upon proper waiver by the applicant.

b. The Iowa law enforcement academy shall have prescheduled testing dates each fiscal year. Nonscheduled testing dates may also be provided.

c. The administration of the Stanard & Associates' National Police Officer Selection Test (POST) and the Minnesota Multiphasic Personality Inventory 2 (MMPI-2) shall be in accordance with directions of the Iowa law enforcement academy.

2.2(4) Cognitive test. Rescinded IAB 3/25/20, effective 4/29/20.

2.2(5) Personality tests.

a. Those law enforcement agencies which choose to administer, score, or interpret the MMPI-2 without using the academy's testing services shall forward to the academy psychological testing information on any individual hired within 14 days of the date hired. Such information shall include, but not be limited to, all scores from MMPI-2 scales used in the evaluation, the MMPI-2 answer sheet, and any resulting reports.

b. The Minnesota Multiphasic Personality Inventory 2 (MMPI-2) test may be administered to applicants who are not in the final selection process.

2.2(6) Cost of tests. The academy will establish and post fee schedules for costs of administering and evaluating the psychological and cognitive test or tests mandated by the academy for agencies who choose to utilize academy testing services.

The cost of the POST test shall be paid by the agencies for which testing is conducted to Stanard & Associates in accordance with the fee schedule approved by and posted at the Iowa law enforcement academy.

2.2(7) Availability of tests scores.

a. Forwarding of cognitive test results. Individual cognitive test scores of cognitive tests purchased through the Iowa law enforcement academy shall be provided by the Iowa law enforcement academy to prospective employing agencies upon request and proper waiver by the applicant for a minimal handling fee.

b. Forwarding of Minnesota Multiphasic Personality Inventory 2 (MMPI-2) test results. The evaluation by the Iowa law enforcement academy of Minnesota Multiphasic Personality Inventory 2 tests will be available to any prospective employing agency upon request and proper waiver by the applicant for a minimal handling fee.

c. Certified law enforcement officers. Law enforcement officers certified through training by the Iowa law enforcement academy are not required to take a cognitive test but may be required to do so at the discretion of the employing agency.

d. Rescinded IAB 9/22/99, effective 10/27/99.

e. Individual POST test scores shall be forwarded by Stanard & Associates to prospective employing agencies upon request and payment of a fee in accordance with the fee schedule approved by and posted at the Iowa law enforcement academy.

f. Individual POST test scores must be postmarked and forwarded to Stanard & Associates within one business day of the date of the examination.

g. Only scores forwarded to Stanard & Associates will be recognized as valid and become part of the Iowa database.

2.2(8) Tests are valid for specific period.

a. The Iowa law enforcement academy evaluations of the Minnesota Multiphasic Personality Inventory 2 may only be used for 12 months to comply with these testing rules. Any applicant who has not been hired or placed upon a civil service certified list within 12 months of taking the Minnesota Multiphasic Personality Inventory 2 test must retake the examination and, before the applicant is hired, the results of the examination must be considered by the hiring authority.

b. Rescinded IAB 9/22/99, effective 10/27/99.

c. At its discretion the employing agency may elect to require an applicant to retake any Iowa law enforcement academy required psychological test as well as any other tests that it may deem necessary in its selection process.

d. POST test scores shall be valid for a period of one year from the date of the examination. An applicant who has not been hired or placed upon a civil service certified list within one year of taking this test must retake and successfully pass the examination before being hired. A person may retest on the same version of the POST examination once within a 12-month period, with a minimum required delay of 90 days before the retest. No delay in retesting is required when a person is given an alternate version of the POST examination.

e. The employing law enforcement agency or appropriate civil service commission retains the exclusive right to decide whether an individual shall be allowed to retest or take an alternate version of the POST examination as provided by these rules.

2.2(9) Construction. Nothing in these rules should be construed to preclude a Civil Service Commission or employing agency from requiring an applicant for a law enforcement position to take tests other than those mandated by these rules so long as the applicant in the final selection process has complied with these rules. These rules shall not be construed as altering or changing the current authority of a Civil Service Commission.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—2.3(80B) Officers moving from agency to agency.

2.3(1) A certified Iowa peace officer who has previously met all the requirements of rule 501—2.1(80B) and who intends to move employment from one Iowa law enforcement agency to another Iowa law enforcement agency, or who intends to be employed as a certified peace officer by more than one Iowa law enforcement agency simultaneously, shall:

a. Undergo a psychological examination as provided in rule 501—2.2(80B) of this chapter, and

b. Be of good moral character as determined by a thorough background investigation by the hiring agency, including, but not limited to, a fingerprint search conducted by the Iowa division of criminal investigation and Federal Bureau of Investigation. If the results of the fingerprint file checks cannot reasonably be obtained prior to the time of appointment, the hiring shall be considered conditional until such time as the results are received and reviewed by the appointing agency.

2.3(2) Except as otherwise specified, the provisions of rule 501—2.1(80B) of this chapter do not need to be reverified upon the movement of employment from one Iowa law enforcement agency to another Iowa law enforcement agency or upon being employed by more than one Iowa law enforcement agency simultaneously if the certified Iowa peace officer met all of the requirements of rule 501—2.1(80B) when the officer was initially hired as an Iowa peace officer and if, without a break of not more than 180 days from law enforcement service, the officer is hired by another Iowa law enforcement agency.

2.3(3) A certified Iowa peace officer who has previously met all the requirements of rule 501—2.1(80B) and who intends to work at the Iowa law enforcement academy shall meet the requirements as outlined in this chapter effective October 20, 2004. Certified Iowa peace officers who are working at the Iowa law enforcement academy before October 20, 2004, may be considered regular peace officers in an active sworn status, and the requirements outlined in 2.3(1) and 2.3(2) shall be waived.

501—2.4(80B) Officers in agencies under intergovernmental agreements. The provisions of rule 501—2.1(80B) do not need to be reverified by officers when jurisdictions enter into an intergovernmental agreement under the provisions of Iowa Code chapter 28E for the sharing of law enforcement services by those jurisdictions and officers if the execution, filing and recording of the agreement conform to the requirements of Iowa law and a certified copy is provided to the director of the academy; however, this does not apply to the establishment of a unified law enforcement district as defined in Iowa Code section 28E.21, wherein a new legal entity or political subdivision is established.

501—2.5(80B) Higher standards not prohibited. While no person can be selected, hired or appointed as an Iowa law enforcement officer who does not meet minimum requirements, agencies are not limited or restricted in establishing additional standards.

These rules are intended to implement Iowa Code sections 80B.11 and 80B.11B.

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◇ Two or more ARCs

CHAPTER 3
CERTIFICATION OF LAW ENFORCEMENT OFFICERS

[Appeared as Ch 1 prior to 4/10/85]

[Prior to 3/11/87, Law Enforcement Academy[550] Ch 3]

501—3.1(80B) Certification through training required for all law enforcement officers.

3.1(1) All law enforcement officers must be certified through the successful completion of training at an approved law enforcement training facility in order to remain eligible for employment. As a condition precedent to enrollment in a certifying training program, the Iowa law enforcement academy must be provided with verification by the enrollee's hiring agency that the minimum standards for Iowa law enforcement officers have been met as provided in rule 501—2.1(80B), except for a person elected or appointed as sheriff who may choose to be exempted from the requirement of subrule 2.1(6), and may determine not to participate in physical training and who shall then be eligible only for certification as provided in subrule 3.1(2). Officers must be certified within one year of their employment, except sheriffs who must be certified within one year of taking office. (See rule 501—3.8(80B) for certification by testing requirements.)

3.1(2) A person elected or appointed sheriff who otherwise successfully completes a basic training course except for the physical training requirements, as provided by Iowa Code section 331.651(1), shall be granted certification limited to and valid only for the position of sheriff of the county in which the person was elected or appointed.

3.1(3) The academy council may, at the council's discretion, extend the one-year time period in which an officer must become certified for up to 180 days after a showing of "undue hardship" by the officer or the officer's hiring agency. To be considered for an extension of the one-year certification period, the person or agency requesting the extension must initiate the request in writing, not less than 10 days prior to the council meeting at which it is to be discussed, and then make a presentation to the council at the next regularly scheduled meeting of the council. Extensions shall not be liberally granted and shall only be granted after a showing that all other alternatives to an extension have been considered and rejected.

3.1(4) In accordance with Iowa Code section 80B.17, the one-year time period in which an officer must become certified is automatically extended for up to 180 days for an officer who is enrolled in training within 12 months of initial appointment. For purposes of this subrule, "enrolled" means physically present in and currently attending a basic certification training class.

3.1(5) The time period within which a person must achieve certification as a law enforcement officer in the state of Iowa as specified in rule 501—3.1(80B) shall commence on the day a person is first employed as a regular law enforcement officer in the state of Iowa. Any subsequent changes in a law enforcement officer's employment status, including transfers to a different employing agency, shall not toll or otherwise extend the certification period.

3.1(6) Should a person employed as a law enforcement officer fail to achieve certification within the time period or any extensions allowed by rule 501—3.1(80B), that person shall not be eligible for employment as and shall not serve as a regular or a reserve law enforcement officer in the state of Iowa for a period of not less than one year from the date the time period in which to achieve certification specified in rule 501—3.1(80B) expired, or from the date that the person was last employed as a regular law enforcement officer in the state of Iowa, whichever comes first.

501—3.2(80B) Law enforcement status forms furnished to academy. Within ten days of any of the following occurrences, the academy will be so advised by use of prescribed forms:

1. Any hiring or termination of personnel.
2. Change of status of existing personnel (e.g., promotions).
3. Satisfactory completion of all law enforcement training not sponsored by the academy.
4. Accrual of college credits.

501—3.3(80B) Standard certifying courses for approved law enforcement facilities. The standard certifying courses of study at an approved law enforcement training facility are:

1. The long course, consisting of 620 hours to be completed within a 25-week period; and
2. The short course, consisting of 400 hours to be completed within a 20-week period.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—3.4(80B) Qualifications for attendance at short course. In order to be eligible for enrollment in the certification through the short course, the individual officer must possess at least one of the following qualifications:

3.4(1) Have satisfactorily completed a two-year or four-year police science or criminal justice program of which at least 20 credit hours were dedicated to police science or criminal justice coursework at an accredited educational institution and documentation furnished to the academy.

3.4(2) Have satisfactorily completed law enforcement training in another state commensurate with basic training required in Iowa, and be able to provide verification of same.

This rule is intended to implement Iowa Code section 80B.11.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—3.5(80B) Curriculum for long course.

3.5(1) Program administration 24 hours

- a. Duty assignments.
- b. Examinations.
- c. Family day.
- d. Graduation.
- e. Registration/orientation.
- f. Student advisor meeting.

3.5(2) Patrol procedures 55 hours

- a. Active shooter response training.
- b. Alcohol licensee compliance.
- c. Animal control procedures.
- d. Basic incident command (IS-100 and IS-700).
- e. Felony calls in progress (includes building searches).
- f. Fire calls.
- g. Gangs.
- h. Hazardous materials.
- i. Iowa system communication including NCIC (National Crime Information Center).
- j. Meth lab safety.
- k. Observation and perception.
- l. Patrol techniques and beat assignments.
- m. Radar enforcement.
- n. Radio communications.
- o. Terrorism awareness.
- p. Traffic direction.
- q. Traffic law enforcement.
- r. Weather preparedness.

3.5(3) Tactical skills 188 hours

- a. Chemical spray.
- b. Defensive tactics.
- c. Expandable baton training.
- d. Firearms (including 6 hours of night fire).
- e. Firearms training simulator.
- f. Risk management.
- g. Vehicle operations.
- h. Vehicle stops (including 2 hours of night vehicle stops).

3.5(4) Life skills 123 hours

- a. Below 100.

- b. Bloodborne pathogens.
- c. Blue courage.
- d. Crisis intervention training.
- e. Critical incident stress management.
- f. Federal color of law (aspects of use of force).
- g. Iowa law enforcement emergency care provider (minimum of 32 hours of classroom).
- h. Mental health emergencies.
- i. Physical training.
- j. Special needs population.
- k. Stress management.
- l. Survival awareness.
- 3.5(5) Investigation 112 hours**
- a. Bombing and arson.
- b. Burglary.
- c. Card fraud.
- d. Collision investigation.
- e. Crime scene search and recording.
- f. Death investigation.
- g. Document fraud.
- h. Domestic abuse investigation (including 4 hours of practical).
- i. Financial crimes.
- j. Fingerprinting.
- k. Forensic science and the DCI laboratory.
- l. Hate crimes.
- m. Human trafficking.
- n. Insurance fraud.
- o. Iowa lottery security.
- p. Iowa missing persons.
- q. Mandatory reporting of child and dependent adult abuse.
- r. Narcotics investigation.
- s. OWI enforcement (includes chemical testing, evidentiary breath testing device training and drug recognition for street officers).
- t. Photography.
- u. Sexual abuse investigation.
- v. Stalking.
- w. Standardized field sobriety testing.
- x. Street intoxication.
- y. Vehicle theft.
- 3.5(6) Legal topics 67 hours**
- a. Civil liability.
- b. Confessions and admissions.
- c. Criminal law.
- d. Juvenile law.
- e. Law of arrest.
- f. Motor vehicle law.
- g. Narcotics law.
- h. OWI legal.
- i. Peace officer and management rights.
- j. Procedural due process.
- k. Rules of evidence.
- l. Search and seizure.
- m. Use of force.

- 3.5(7) Communication skills** 36 hours
 - a. Deaf culture.
 - b. Death notification.
 - c. Interviews and interrogations.
 - d. Moot court.
 - e. Report writing and investigative note-taking.
 - f. Social media.
 - g. Testifying in court.
 - h. Verbal defense and influence.
- 3.5(8) Foundations of American policing** 15 hours
 - a. Community relations.
 - b. Court organization.
 - c. Cultural competency.
 - d. Discretion.
 - e. Ethics and professionalism.
 - f. Jail operations/corrections/civil process.
 - g. Race relations.
 - h. Unbiased policing.

TOTAL HOURS: 620

This rule is intended to implement Iowa Code section 80B.11.
[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—3.6(80B) Curriculum for short course.

- 3.6(1) Program administration** 16 hours
 - a. Examinations.
 - b. Graduation.
 - c. Registration/orientation.
- 3.6(2) Patrol procedures** 35 hours
 - a. Active shooter response training.
 - b. Basic incident command.
 - c. Felony calls in progress (includes building searches).
 - d. Gangs.
 - e. Hazardous materials.
 - f. Iowa system communication including NCIC.
 - g. Meth labs.
 - h. Radar enforcement.
 - i. Radio communications.
 - j. Traffic direction.
- 3.6(3) Tactical skills** 128 hours
 - a. Chemical spray.
 - b. Defensive tactics.
 - c. Expandable baton training.
 - d. Firearms (including 6 hours of night fire).
 - e. Vehicle operations.
 - f. Vehicle stops (including 2 hours of night vehicle stops).
- 3.6(4) Life skills** 73 hours
 - a. Below 100.
 - b. Bloodborne pathogens.
 - c. Blue courage.
 - d. Crisis intervention training.
 - e. Iowa law enforcement emergency care provider (minimum of 32 hours of classroom).
 - f. Mental health.

- g. Physical training.
- 3.6(5) Investigation 56 hours**
- a. Collision investigation.
- b. Crime scene search and recording.
- c. Card fraud.
- d. Death investigation.
- e. Domestic abuse investigation (including 2 hours of practical).
- f. Fingerprinting.
- g. Human trafficking.
- h. Iowa lottery security.
- i. Mandatory reporting.
- j. Narcotics investigation.
- k. OWI enforcement (includes chemical testing, evidentiary breath testing device training and drug recognition for street officers).
- l. Photography.
- m. Sexual abuse investigation.
- 3.6(6) Legal topics 57 hours**
- a. Confessions and admissions.
- b. Criminal law.
- c. Juvenile law.
- d. Law of arrest.
- e. Motor vehicle law.
- f. Narcotics law.
- g. OWI legal.
- h. Rules of evidence.
- i. Search and seizure.
- j. Use of force.
- 3.6(7) Communication skills 29 hours**
- a. Interviews and interrogations.
- b. Report writing and investigative note-taking.
- c. Testifying in court.
- d. Verbal defense and influence.
- 3.6(8) Foundations of American policing 6 hours**
- a. Cultural competency.
- b. Ethics and professionalism.
- c. Unbiased policing.

TOTAL HOURS: 400

This rule is intended to implement Iowa Code section 80B.11.
[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—3.7(80B) Special certification. The director of the academy, subject to the approval of the council may develop special certifying training courses in consideration of the varying factors and special requirements of certain law enforcement agencies.

501—3.8(80B) Certification through examination. Law enforcement officers who have been certified in another state may, upon application to the director with council approval, take a competency test or tests to gain Iowa law enforcement officer certification. Successful completion of the required test or tests will result in certification by the council. The test or tests will be prepared and administered by the academy or its designee, and the passing score will be determined by the academy. The required test or tests will be based upon the officer’s prior law enforcement training and experience as follows:

3.8(1) Five or more years of law enforcement experience. Officers with more than five years of full-time law enforcement experience will be required to pass a test or tests which will primarily measure

the officer's knowledge of Iowa laws. The test or tests will include, but need not be limited to, such topics as criminal law, motor vehicle law, juvenile law, law of arrest, law of search and seizure, and law regarding the use of force.

3.8(2) *Less than five years of law enforcement experience.* Officers with less than five years of full-time law enforcement experience will be required to pass a comprehensive test or tests which will focus on all phases of law enforcement. The test or tests will include, but need not be limited to, such topics as criminal law, juvenile law, motor vehicle law, law of arrest, law of search and seizure, law regarding the use of force, confessions and admissions, crime prevention, community relations, minority relations, crime scene investigation, vehicle stops, and rules of evidence.

3.8(3) *Tabulating previous law enforcement experience.* In tabulating whether an officer has met the law enforcement experience requirement, no credit will be given for experience received from the officer's current employment.

3.8(4) *Criteria to be eligible to certify through examination.* The following will be prerequisites for certification through examination:

a. Successful completion of a minimum 160-hour certifying basic law enforcement training school in another state, which certification has not been withdrawn by the certifying state.

b. Firing a verified score of 80 percent or greater with the officer's service handgun since the individual's appointment as an Iowa law enforcement officer, and which course of fire was prescribed by the academy and administered by the Iowa law enforcement academy or its designee.

c. Possession of a current Iowa law enforcement emergency care provider (ILEECP) card or another appropriate certification recognized by the Iowa law enforcement academy.

3.8(5) *Application and testing periods.* Application for certification through examination shall be made within 120 days of the applicant's hiring date, unless a determination is made by the academy council that this time period should be extended for "good cause." Failure to make timely application for certification through examination may result in the applicant's being required to attend an academy certifying school.

3.8(6) *Retesting requirements.* Failure to successfully complete this examination will require retesting within 60 days in the areas failed. If any area is failed a second time, it will be necessary for the individual to attend and satisfactorily complete training at the academy covering those areas of deficiency. Successful completion of the training will result in law enforcement officer certification by the academy council.

3.8(7) *One year's absence from law enforcement shall require training.* An officer who has not served as a regular law enforcement officer during the 12-month period preceding the officer's hiring date will be required to attend a certifying school.

501—3.9(80B) Special certification through examination. This rule is promulgated by the academy in compliance with 1996 Iowa Acts, chapter 1201. Persons having successfully completed the Federal Bureau of Investigation National Academy, having corrected Snellen vision in both eyes of 20/20 or better, and having been employed on or before January 1, 1996, as chief of police of a city in the state of Iowa with a population of 20,000 or more may, upon application to the director with council approval, take a competency test or tests to gain Iowa law enforcement officer certification. Successful completion of the required test or tests will result in certification by the council. The test or tests will be prepared and administered by the academy and the passing score will be determined by the academy. Persons eligible under this rule who successfully complete the long form examination shall be granted certification limited to and valid only for the position for which the person was hired.

3.9(1) *Criteria.* The following will be prerequisites for special certification through examination under this rule:

a. Firing a verified score of 80 percent or greater with the officer's service handgun which course of fire was prescribed and administered by the Iowa law enforcement academy.

b. The applicant must possess or obtain current Iowa law enforcement emergency care provider (ILEECP) certification or current emergency medical care provider certification issued by the Iowa department of public health and approved by the academy, and current course completion in

cardiopulmonary resuscitation, AED and foreign body airway obstruction for all age groups according to national standards, with documentation furnished to the academy.

3.9(2) *Application and testing periods.* Application shall be made within 120 days of the effective date of this rule. Failure to make timely application will result in the applicant's being required to attend an academy certifying school.

3.9(3) *Retesting requirements.* Failure to successfully complete the examination will require retesting within 60 days in the areas failed. If any area is failed a second time, the applicant will be required to attend and satisfactorily complete training at the academy covering those areas of deficiency. Successful completion of the training will result in law enforcement officer certification by the academy council.

[ARC 3997C, IAB 9/12/18, effective 10/17/18]

501—3.10(80B) More extensive certifying course curricula not prohibited. While no law enforcement training facility will be approved by the Iowa law enforcement academy council which does not meet the minimum requirements of these certifying course curricula, this in no way limits or restricts any law enforcement training facility in instituting a certifying course curriculum that surpasses the curriculum established pursuant to Iowa Code chapter 80B.

This rule is intended to implement Iowa Code chapter 80B.

501—3.11(80B) Time frame—tolled. The time frame requirements for completion of any mandatory training are tolled during the period a law enforcement officer is called to active military service.

501—3.12(80B) Training of an individual who intends to become certified as a law enforcement officer.

3.12(1) An individual who has not yet been hired or started employment as an Iowa sworn peace officer may apply for attendance at the Iowa law enforcement academy (ILEA) or, if qualified as provided for in subrule 3.4(1), at a short course of study at an approved law enforcement training program if such individual is sponsored by an Iowa law enforcement agency.

a. The individual must submit an application packet approved and provided by the Iowa law enforcement academy at least 30 days in advance of the course of study that the person wants to attend if the hiring standards are conducted by a sponsoring agency and at least 60 days in advance of the course of study that the person wants to attend if the hiring standards are conducted by ILEA. An administrative fee, to be established by the academy, shall accompany the application packet.

b. The sponsoring Iowa law enforcement agency must certify that the agency intends to hire within the next 18 months or has hired the individual as a law enforcement officer.

c. The fees to attend the Iowa law enforcement academy will be collected as follows:

(1) 25 percent at the time position in class is reserved. (This fee is nonrefundable.)

(2) 25 percent on first day of the academy class.

(3) The remaining amount to reach full payment of all ILEA training fees must be received by the end of the fourth week or the individual will be dismissed from the academy.

d. The fees to attend a short course of study at an approved law enforcement training program will be collected as determined by that entity.

3.12(2) Hiring standards. An individual who files an application under subrule 3.12(1) must meet all hiring standards as established by the academy in rules 501—2.1(80B) and 501—2.2(80B).

a. The sponsoring law enforcement agency may conduct required testing including medical/psychological/cognitive examinations, thorough background investigation and other matters as required by rules 501—2.1(80B) and 501—2.2(80B). The sponsoring law enforcement agency that conducts the required testing must certify that all hiring standards have been met and submit proof of the same as required by Iowa law enforcement academy administrative rules and on forms provided by the academy.

b. The academy shall conduct the required testing including medical/psychological/cognitive examinations, thorough background investigation and other matters as required by rules 501—2.1(80B)

and 501—2.2(80B) if the sponsoring agency has not done so. The academy will establish fees for conducting the hiring standards requirements, including the background check, to be paid by the individual filing the application. The fees must be paid before the testing occurs.

3.12(3) Application for a short course of study at an approved law enforcement training program. An individual applying for attendance at a short course of study at an approved law enforcement training program shall submit proof of successful completion of a two-year or four-year police science or criminal justice program at an accredited educational institution in this state as approved by the academy. The proof must include a letter from the registrar certifying the person's graduation and a certified transcript of courses taken and grades received. The proof must be submitted 30 days in advance of the course of study that the person wants to attend.

3.12(4) Permission to attend. An individual shall not be granted permission to attend an approved law enforcement training program if such acceptance would result in the nonacceptance of another qualifying applicant who is a law enforcement officer.

3.12(5) Certification. The academy will not grant certification until an individual is employed by an Iowa law enforcement agency and has met required hiring standards and successfully completed certification testing.

a. The following hiring standards must be reverified if the individual is not hired by an Iowa law enforcement agency during the first 12 months following completion of the course of study.

(1) The Iowa law enforcement academy evaluations of the Minnesota Multiphasic Personality Inventory (MMPI) may be used for only 12 months to comply with this rule. Any individual who has not been hired or placed upon a civil service certified list within the first 12 months following completion of the course of study must retake the MMPI and, before the individual is certified, the results of the MMPI must be approved by the hiring authority.

(2) Standard & Associates' National Police Officer Selection Test (POST) test scores shall be valid for a period of 12 months from the date of completion of the course of study. An individual who has not been hired or placed upon a civil service certified list within 12 months must retake and successfully pass the examination before being certified.

(3) The individual must be examined by a licensed physician or surgeon and meet the physical requirements necessary to fulfill the responsibilities of a law enforcement officer.

(4) The individual must successfully pass a physical test adopted by the Iowa law enforcement academy.

b. An individual may be certified in the following areas only after being employed by an Iowa law enforcement agency:

(1) Iowa Law Enforcement Emergency Care Provider.

(2) Implied consent.

(3) Standardized field sobriety testing.

(4) Firearms qualification with the hiring agency's weapon and ammunition.

Certification will be awarded in the above areas if the individual is employed by an Iowa law enforcement agency within the first 12 months following completion of the basic training course of study and when the following requirements are met. All individuals, once employed by an Iowa law enforcement agency, must undergo testing in the firearms qualifications with the hiring agency's weapon and ammunition at the direction of an instructor certified in firearms by the Iowa law enforcement academy. Documentation of this testing and scores must be submitted to the Iowa law enforcement academy. The individual will be certified upon successful completion of the firearms qualification and review of the testing results completed during training at the Iowa law enforcement academy or at a short course of study at an approved law enforcement training program.

If the individual is not employed within a 12-month period after completing basic training at the Iowa law enforcement academy or at a short course of study at an approved law enforcement training program, the individual will be required to retake the required training for Iowa Law Enforcement Emergency Care Provider, implied consent, and standardized field sobriety testing. Successful completion and documentation of this training must be submitted to the Iowa law enforcement academy before certification can be granted.

3.12(6) Employment within 18 months. The individual must be employed by an Iowa law enforcement agency within 18 months of completion of the course of study in order to receive certification. An individual shall not be certified under rule 501—3.12(80B) if the individual is not employed by an Iowa law enforcement agency within 18 months of completion of the course of study.

This rule is intended to implement 2003 Iowa Acts, Senate Files 352 and 453.

These rules are intended to implement Iowa Code chapter 80B.

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¹ Effective date of 3/1/89 for rescission of 3.4(1) delayed 70 days by the Administrative Rules Review Committee.

² Effective date delayed until the adjournment of the 1994 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its meeting held May 12, 1993.

CHAPTER 6 DECERTIFICATION

[Ch 6 re Organization and Administration transferred to Ch 1, 4/10/85 IAC]
[Prior to 3/11/87, Law Enforcement Academy[550] Ch 6]

501—6.1(80B) Scope of rules. The rules contained in this chapter pertaining to practices and procedures are designed to implement the requirements of Iowa Code chapters 80B and 17A. These rules shall govern the practice, procedures, and conduct of contested case proceedings held in the revocation of a law enforcement officer's certification.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.2(80B,80D) Grounds for revocation.

6.2(1) Mandatory revocation. The council shall revoke a law enforcement officer's certification or a reserve peace officer's certification if:

- a. The law enforcement officer or reserve peace officer pleads guilty to or is convicted of a felony;
- b. The law enforcement officer or reserve peace officer manufactures, sells, or conspires to manufacture or sell an illegal drug other than an authorized act in connection with official duties;
- c. The law enforcement officer or reserve peace officer pleads guilty to or is convicted of a crime constituting a misdemeanor crime of domestic violence or other domestic abuse including other offenses or lesser included offenses stemming from domestic abuse;
- d. The law enforcement officer or reserve peace officer pleads guilty to or is convicted of any offense classified as a tier I, tier II, or tier III sex offense in Iowa Code chapter 692A.

6.2(2) Discretionary revocation. The director or the director's designee shall have the authority to conduct a preliminary inquiry and shall have the authority to determine which matters shall be referred to the council for consideration. The council, at its discretion, may revoke or suspend a law enforcement officer's or a reserve peace officer's certification under any of the following circumstances:

- a. The law enforcement officer or reserve peace officer has been discharged for "good cause" from employment as a law enforcement officer or from appointment as a reserve peace officer.
- b. The law enforcement officer or reserve peace officer leaves, voluntarily quits, or the officer's position is eliminated when disciplinary action was imminent or pending which could have resulted in the law enforcement officer being discharged or the reserve peace officer being removed for "good cause."
- c. The law enforcement officer or reserve peace officer:
 - (1) Makes, tenders, or certifies to a material false statement in a document prescribed by the academy or otherwise provided for or authorized by these rules, or in any other document intended to induce the academy or the council to take or withhold action.
 - (2) Falsifies or makes misrepresentations on an employment application submitted to any Iowa law enforcement agency or any other public document required to be completed by the officer.
 - (3) Testifies falsely in any court of law or administrative hearing.
 - (4) Commits any act of moral turpitude as defined in 501—subrule 2.1(5). A copy of the record of conviction of or plea of guilty to a crime of moral turpitude shall be conclusive evidence; however, a conviction or plea of guilty is not required.
 - (5) Uses or possesses an illegal substance other than in connection with official duties.
 - (6) Fails to comply with the requirements of 501—Chapters 8 and 10 relative to in-service training.
 - (7) Is decertified in any other state where the law enforcement officer or reserve peace officer may be certified.

d. The law enforcement officer has failed to reimburse the employing agency for costs incurred by that agency, including fees paid to the academy, clothing vendor costs, meal costs, uniform/equipment costs, and the officer's salary paid during the academy if the officer leaves that agency and is employed by another law enforcement agency within a period of four years following completion of the certification training, under the following conditions:

- (1) A written agreement or contract of employment must be entered into by the officer and the employing agency contemporaneously with the date of employment. The agreement shall specifically provide for the reimbursement to the employing agency by the officer of the costs of training incurred by

the employing agency, including fees paid to the Iowa law enforcement academy, clothing vendor costs, meal costs, uniform/equipment costs, and the officer's salary paid during the academy. The agreement must:

1. Specify the amount of reimbursement that the officer agrees to pay;
2. Set forth the time period within which this reimbursement will be made, which shall be on a declining scale similar to the provisions of Iowa Code section 384.15(7);
3. Contain a statement that if reimbursement is not made in accordance with the agreement, the officer understands that the employing agency may at its option seek the officer's decertification as an Iowa law enforcement officer; and
4. Contain a provision to the effect that the agreement or contract of employment is for bona fide employment of the officer and not for the purpose of achieving certification for the officer by way of "sponsorship" through the academy.

(2) A recommendation for decertification must be verified under oath by the administrator of the employing agency with which the officer contracted under this rule. The recommendation for decertification must contain the following information:

1. Have attached a copy of the agreement referred to in subparagraph 6.2(2)"d"(1) above;
2. Include an order of judgment from a small claims or civil court;
3. State that the officer has not made reimbursement to the employing agency as provided in the agreement, and clearly describe the nature of the default;
4. List an accounting of all payments made by the officer to the employing agency under the agreement, and specify the balance due;
5. State that written notice of the default or judgment has been given to the officer, that the officer has been provided opportunity to correct the default, and that there remains no reasonable alternative to decertification;
6. Specifically recommend that the council commence proceedings to decertify the officer, and state that the employing agency will do all things necessary to cooperate in this effort; and
7. Set out the last-known address of the officer, the officer's telephone number, and the officer's last-known place of employment.

(3) The recommendation for decertification must be submitted to the academy not more than one year after the date of the officer's default, unless the council, upon written application and for good cause shown, grants further time in which to submit the recommendation.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.3(80B,17A) Service and filing of pleadings and other papers.

6.3(1) *Computation of time and filing of documents.* The computation of time and filing of documents shall be in compliance with Iowa Code section 4.1(34).

6.3(2) *Service—when required.* Except where otherwise provided by law, every document filed in a contested case proceeding shall be served upon each of the parties of record to the proceeding, simultaneously with its 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.

6.3(3) *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.

6.3(4) *Filing—when required.* After the notice of hearing, all documents in a contested case proceeding shall be filed with the council at Iowa Law Enforcement Academy, Camp Dodge, Johnston, Iowa 50131. All documents that are required to be served upon a party shall be filed simultaneously with the council and, if the presiding officer is not the council, at a location designated by the presiding officer.

6.3(5) *Filing—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the council, delivered to an established courier service for immediate delivery

to that office, or mailed by first-class mail or state interoffice mail to that office, so long as there is proof of mailing.

6.3(6) Proof of mailing. Proof of mailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or 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 (document description) addressed to the (agency office and address) 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 5006C, IAB 3/25/20, effective 4/29/20]

501—6.4(80B,17A) Prehearing procedures.

6.4(1) Council subpoenas. Prior to the commencement of a contested case, the council may exercise the authority to subpoena books, papers, and records and shall have all other subpoena powers conferred upon it by law.

6.4(2) Commencement of contested case proceedings. Contested case proceedings shall be commenced by the delivery of a notice by the council or its designee requiring the affected law enforcement officer to appear and show cause as to why certification to be a law enforcement officer in the state of Iowa should not be revoked or suspended. Notice may be given in the same manner as the service of original notice as provided in the Iowa Rules of Civil Procedure; by certified restricted mail, return receipt requested; by signed acknowledgment accepting service; or, when service cannot be accomplished using the aforementioned methods, notice of hearing shall be published once each week for three consecutive weeks in a newspaper of general circulation, published or circulated in the county of last-known residence of the affected law enforcement officer. The first notice of hearing shall be published at least 30 days prior to the scheduled hearing.

The notice shall include:

- 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 held;
- c. A reference to the particular sections of the statutes and rules involved;
- d. A short and plain statement of the grounds for revocation or suspension and relevant facts;
- e. Reference to the procedural rules governing conduct of the contested case proceeding; and
- f. Identification of the presiding officer, if known. If not known, a description of who will serve as presiding officer.

Notice may also be sent in the manner aforementioned or by ordinary mail to any other interested party. After the delivery of the notice commencing the contested case proceedings, the presiding officer may allow further response of pleadings by the party as, in the presiding officer's discretion, is deemed necessary and appropriate.

6.4(3) Discovery. The following discovery procedures available in the Iowa Rules of Civil Procedure are available to the parties: depositions upon oral examination or written questions; written interrogatories; production of documents, electronically stored information, and things; and requests for admission. Unless lengthened or shortened by the presiding officer, the time frames for discovery in the specific Iowa Rules of Civil Procedure govern those specific procedures.

a. Iowa Rules of Civil Procedure 1.701 through 1.717 regarding depositions shall apply to any depositions taken in a contested case proceeding. Any party taking a deposition in a contested case shall be responsible for any deposition costs, unless otherwise specified or allocated in an order. Deposition costs include, but are not limited to, reimbursement for mileage of the deponent, costs of a certified shorthand reporter, and expert witness fees, as applicable.

b. Iowa Rule of Civil Procedure 1.509 shall apply to any interrogatories propounded in a contested case proceeding.

c. Iowa Rule of Civil Procedure 1.512 shall apply to any requests for production of documents, electronically stored information, and things in a contested case proceeding.

d. Iowa Rule of Civil Procedure 1.510 shall apply to any requests for admission in a contested case proceeding. Iowa Rule of Civil Procedure 1.511 regarding the effect of an admission shall apply in contested case proceedings.

e. The mandatory disclosure and discovery conference requirements in Iowa Rules of Civil Procedure 1.500 and 1.507 do not apply to contested case proceedings. However, upon application by a party, the presiding officer may order the parties to comply with these procedures unless doing so would unreasonably complicate the proceedings or impose an undue hardship.

f. Iowa Rule of Civil Procedure 1.508 shall apply to discovery of any experts identified by a party to a contested case proceeding.

g. A party may file a motion to compel or other motion related to discovery in accordance with this subrule. Any motion filed with the presiding officer 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. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is lengthened or shortened by the presiding officer. The presiding officer may rule on the basis of the written motion and any response or may order argument on the motion.

h. Evidence obtained in such discovery may be used in contested case proceedings if the evidence would otherwise be admissible in the contested case proceedings.

6.4(4) *Presiding officer subpoenas.* The presiding officer may issue subpoenas to a party on request, as permitted by law, compelling the attendance of witnesses and the production of books, papers, records or other real evidence.

6.4(5) *Motions.* No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

a. 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 agency or the presiding officer.

b. The presiding officer may schedule oral arguments on any motion.

c. Motions pertaining to the hearing, including motions for summary judgment, must 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 agency or an order of the presiding officer.

6.4(6) *Prehearing conference.* The presiding officer, upon its own motion or upon the written request of one of the parties, may, in the presiding officer's discretion and upon written notice, direct the parties to appear at a specified time and place before the presiding officer for a prehearing conference to consider:

a. The possibility or desirability of waiving any provision of these rules relating to contested case proceedings by written stipulation representing an informed mutual consent.

b. A necessity or desirability of setting a new date for hearing.

c. The simplification of issues.

d. The necessity or desirability of amending the pleadings for purposes of clarification, amplification or limitation.

e. The possibility of agreeing to the admission of facts, documents or records not substantially controverted, to avoid unnecessary introduction of proof.

f. The procedure at the hearing.

g. Limiting the number of witnesses.

h. The names and identification of witnesses and the facts each party will attempt to prove at the hearing.

i. Other matters as may aid in, expedite or simplify the disposition of the proceeding.

Prehearing conferences shall be conducted by telephone unless otherwise ordered. Parties shall exchange witness and exhibit lists in advance of a prehearing conference.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.5(80B,17A) Presiding officer.

6.5(1) The presiding officer assigned to render a proposed decision will be an administrative law judge employed by the Iowa department of inspections and appeals. However, the council in its discretion may elect to preside over a case in lieu of an administrative law judge.

6.5(2) Any party who wishes to request that the presiding officer assigned to render a proposed decision be an administrative law judge employed by the Iowa department of inspections and appeals must file a written request within 20 days after service of a notice of hearing which identifies or describes the presiding officer as the council.

6.5(3) The council may deny the request only upon a finding that one or more of the following apply:

a. Neither the council nor any officer of the council 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. An administrative law judge is unavailable to hear the case within a reasonable time.

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.

6.5(4) The council shall issue a written ruling specifying the grounds for its decision within 20 days after a request for an administrative law judge is filed. If the ruling is contingent upon the availability of an administrative law judge, the parties shall be notified at least ten days prior to hearing if a qualified administrative law judge will not be available.

6.5(5) Unless otherwise provided by law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the council. A party must seek any available intra-agency appeal in order to exhaust adequate administrative remedies.

6.5(6) Unless otherwise provided by law, the council, 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 5006C, IAB 3/25/20, effective 4/29/20]

501—6.6(80B,17A) Disqualification.

6.6(1) A presiding officer or council member 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.

6.6(2) 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 agency 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 and subrules 6.6(3) and 6.11(9).

6.6(3) In a situation where a presiding officer or council member knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

6.6(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 6.6(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party. If the presiding officer determines that disqualification is appropriate, the presiding officer or council member 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 501—6.12(80B,17A) and seek a stay under rule 501—6.16(80B,17A). [ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.7(80B,17A) Continuances. A party has no automatic right to a continuance or delay of the council’s hearing procedure or schedule. However, a party may request a continuance of the presiding officer prior to the date set for hearing. The presiding officer shall have the power to grant continuances. Within seven days of the date set for hearing, no continuances shall be granted except for extraordinary, extenuating or emergency circumstances.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.8(80B,17A) Hearing procedures.

6.8(1) Contested case proceeding. Unless the parties to a contested case proceeding have by written stipulation representing an informed mutual consent waived the provisions of the Act relating to the proceedings, contested case proceedings shall be initiated and culminate in an evidentiary hearing open to the public. Parties shall have been notified of the date and place of the hearing at least 30 days prior thereto.

a. Evidentiary hearings before the council shall be held at the council’s principal office, Iowa Law Enforcement Academy, Camp Dodge, Johnston, Iowa, except that a case may be assigned for hearing elsewhere when deemed necessary to afford a party an opportunity to appear at the hearing with as little inconvenience and expense as practicable.

b. Evidentiary hearings before an administrative law judge shall be held at an appropriate location designated by the department of inspections and appeals.

6.8(2) Conduct of the proceedings.

a. 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. If the presiding officer is the council or a panel thereof, an administrative law judge from the Iowa department of inspections and appeals may be designated to assist the council in conducting proceedings under this chapter. An administrative law judge so designated may rule upon motions and other procedural matters and assist the council in conducting the hearings.

b. Evidentiary proceedings shall be oral and open to the public and shall be recorded either by mechanical means or by certified shorthand reporters. Parties requesting that the hearing be recorded by certified shorthand reporters shall bear the appropriate costs. The record of the oral proceedings or the transcription thereof shall be filed with and maintained by the council for at least five years from the date of the decision.

6.8(3) All objections shall be timely made and stated on the record.

6.8(4) Legal representation.

a. The law enforcement officer has a right to participate in all hearings or prehearing conferences and may be represented by an attorney or another person authorized by law. If the law enforcement officer is not represented by anyone qualified by these rules to make an appearance, the presiding officer shall explain to the law enforcement officer the rules of practice and procedure and generally conduct a hearing in a less formal manner than that used when a law enforcement officer has a representative qualified to appear. It should be the purpose of the presiding officer to assist any law enforcement officer who appears without a representative to the extent necessary to allow a fair presentation of evidence, testimony and arguments on the issues.

b. The office of the attorney general or an attorney designated by the director shall be responsible for prosecuting contested case proceedings under this chapter. The assistant attorney general or other designated attorney assigned to prosecute the contested case shall not represent the council in that case but shall represent the public interest.

6.8(5) 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 argument.

6.8(6) Witnesses may be sequestered during the hearing.

6.8(7) 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.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.9(80B,17A) Evidence.

6.9(1) 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.

6.9(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

6.9(3) Evidence in the proceeding shall be confined to the issues concerning allegations raised on the face of petition for decertification as to which the parties received notice prior to the hearing.

6.9(4) 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.

6.9(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which it is based. 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.

6.9(6) 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.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.10(80B,17A) Default.

6.10(1) 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.

6.10(2) 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.

6.10(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency 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 an appeal of a decision on the merits is timely initiated within the time provided by rule 501—6.14(80B,17A). 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.

6.10(4) 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.

6.10(5) 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.

6.10(6) "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.

6.10(7) 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 501—6.12(80B,17A).

6.10(8) 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.

6.10(9) 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).

6.10(10) 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 501—6.16(80B,17A).

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.11(80B,17A) Ex parte communication.

6.11(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 council or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating, 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.

6.11(2) 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.

6.11(3) Written, oral or other forms of communication are “ex parte” if made without notice and opportunity for all parties to participate.

6.11(4) 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 501—6.3(80B,17A) 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.

6.11(5) Council members acting as presiding officers may communicate with each other without notice or opportunity for parties to participate.

6.11(6) The 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 6.11(1).

6.11(7) 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 501—6.7(80B,17A).

6.11(8) Disclosure of prohibited communications. 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. 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 (or disclosed). 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. 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.

6.11(9) 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.

6.11(10) 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 department. Violation of ex parte communication prohibitions by department personnel shall be reported to (agency to designate person to whom violations should be reported) for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.12(80B,17A) Interlocutory appeals. Upon written request of a party or on its own motion, the council may review an interlocutory order of the presiding officer. In determining whether to do so, the council 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 council 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.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.13(80B,17A) Final decision.

6.13(1) When the council presides over the reception of evidence at the hearing, its decision is a final decision.

6.13(2) When the council does not preside over the reception of evidence at the hearing, the presiding officer shall make a proposed decision. The proposed decision becomes the final decision of the council without further proceedings unless there is an appeal to, or review on motion of, the council within the time provided in rule 501—6.14(80B,17A).

6.13(3) Final decisions shall be served on the affected law enforcement officer using one of the following methods: the same manner as the service of original notice as provided in the Iowa Rules of Civil Procedure; by certified restricted mail, return receipt requested; by signed acknowledgment accepting service; or, when service cannot be accomplished using the aforementioned methods, notice of hearing shall be published once each week for three consecutive weeks in a newspaper of general circulation, published or circulated in the county of last-known residence of the affected law enforcement officer. If the officer is represented by an attorney, the final decision shall be mailed to the attorney. The attorney may waive the requirement to serve the affected law enforcement officer through a written acknowledgment that the attorney is accepting service on behalf of the client.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.14(80B,17A) Appeals and review.

6.14(1) *Appeal by party.* Any adversely affected party may appeal a proposed decision to the council within 30 days after issuance of the proposed decision.

6.14(2) *Review.* The council may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

6.14(3) *Notice of appeal.* An appeal of a proposed decision is initiated by filing a timely notice of appeal with the council. The notice of appeal must be signed by the appealing party or a representative of that party and contain 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; and
- e. The grounds for relief.

6.14(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 nonappealing party, within 14 days of service of the notice of appeal. The council may remand a case to the presiding officer for further hearing or may itself preside at the taking of additional evidence.

6.14(5) *Scheduling.* The council shall issue a schedule for consideration of the appeal.

6.14(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 council may resolve the appeal on the briefs or provide an opportunity for oral argument. The council may shorten or extend the briefing period as appropriate.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.15(80B,17A) Application for rehearing.

6.15(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

6.15(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 council decision on the existing record and whether, on the basis of the grounds enumerated in subrule 6.14(4), the applicant requests an opportunity to submit additional evidence.

6.15(3) *Time of filing.* The application shall be filed with the council within 20 days after issuance of the final decision.

6.15(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 council shall serve copies on all parties.

6.15(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the council grants the application within 20 days after its filing.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.16(80B,17A) Stays of council actions.

6.16(1) *When available.*

a. Any party to a contested case proceeding may petition the council for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the council. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The director may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the council 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.

6.16(2) *When granted.* In determining whether to grant a stay, the director or presiding officer shall consider the factors listed in Iowa Code section 17A.19(5).

6.16(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the council or any other party.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.17(80B,17A) 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. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—6.18(80B,17A) Reinstatement. Any person whose certification has been suspended may apply to the board for reinstatement in accordance with the terms and conditions of the order of suspension and this rule. Any person whose certification has been revoked is not eligible for reinstatement.

6.18(1) All proceedings for reinstatement shall be initiated by the law enforcement officer or reserve peace officer, who shall file with the academy council an application for reinstatement. Such application shall be docketed in the original case in which the certification was suspended. All proceedings upon the application for reinstatement shall be subject to the same rules of procedure as other cases before the academy council.

6.18(2) An application for reinstatement shall allege facts which, if established, will be sufficient to enable the academy council to determine that the basis for the suspension of the law enforcement officer's or reserve peace officer's certification no longer exists and that it will be in the public interest for the

certification to be reinstated. The burden of proof to establish such facts shall be on the law enforcement officer or reserve peace officer seeking reinstatement.

6.18(3) An order denying or granting reinstatement shall be based upon a decision which incorporates findings of fact and conclusions of law.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

These rules are intended to implement Iowa Code chapters 17A and 80B.

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CHAPTER 7
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

501—7.1(17A,22) Definitions. As used in this chapter:

“*Agency*” means the Iowa law enforcement academy.

“*Confidential record*” means a record which is not available as a matter of right for examination and copying by members of the public under applicable provisions of law. Confidential records include records or information contained in records that the agency is prohibited by law from making available for examination by members of the public, and records or information contained in records that are specified as confidential by Iowa Code section 22.7, or other provision of law, but that may be disclosed upon order of a court, the lawful custodian of the record, or by another person duly authorized to release the record. Mere inclusion in a record of information declared confidential by an applicable provision of law does not necessarily make that entire record a confidential record.

“*Custodian*” means the Iowa law enforcement academy, or a person lawfully delegated authority by the Iowa law enforcement academy to act for the agency in implementing Iowa Code chapter 22.

“*Open record*” means a record other than a confidential record.

“*Personally identifiable information*” means information about or pertaining to an individual in a record which identifies the individual and which is contained in a record system.

“*Record*” means the whole or a part of a public record as defined in Iowa Code section 22.1.

“*Record system*” means any group of records under the control of the agency from which a record may be retrieved by a personal identifier such as the name of an individual, number, symbol, or other unique retriever assigned to an individual.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.2(17A,22) Statement of policy. This chapter implements Iowa Code section 22.11 by establishing agency policies and procedures for the maintenance of records. The purpose of this chapter is to facilitate public access to open records. It also seeks to facilitate sound agency determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. This agency is committed to the policies set forth in Iowa Code chapter 22; agency staff shall cooperate with members of the public in implementing the provisions of that chapter.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.3(17A,22) Requests for access to records.

7.3(1) Location of record. A request for access to a record should be directed to the office where the record is kept. If the location of the record is not known by the requester, the request shall be directed to the Iowa Law Enforcement Academy, P.O. Box 130, Camp Dodge, Johnston, Iowa 50131.

7.3(2) Office hours. Open records shall be available during customary office hours, which are 8 a.m. to 4:30 p.m. daily, excluding Saturdays, Sundays and legal holidays.

7.3(3) Request for access. A request for access to open records may be made in writing, by electronic mail, in person or by telephone. The request shall identify the particular records sought by name or description in order to facilitate the location of the record. Mail or telephone requests shall include the name, address, and telephone number of the person requesting the information. A person shall not be required to give a reason for requesting an open record.

7.3(4) Response to requests. Access to an open record shall be provided promptly upon request unless the size or nature of the request makes prompt access infeasible. If the size or nature of the request for access to an open record requires time for compliance, the custodian shall comply with the request as soon as feasible. Access to an open record may be delayed for one of the purposes authorized by Iowa Code section 22.8(4) or 22.10(4). The custodian shall promptly give notice to the requester of the reason for any delay in access to an open record and an estimate of the length of that delay and, upon request, shall promptly provide that notice to the requester in writing.

The custodian of a record may deny access to the record by members of the public only on the grounds that such a denial is warranted under Iowa Code sections 22.8(4) and 22.10(4), or that it is a confidential record, or that its disclosure is prohibited by a court order. Access by members of the public

to a confidential record is limited by law and, therefore, may generally be provided only in accordance with the provisions of rule 501—7.6(17A,22) and other applicable provisions of law.

7.3(5) Security of record. No person may, without permission from the custodian, search or remove any record from agency files. Examination and copying of agency records shall be supervised by the custodian or a designee of the custodian. Records shall be protected from damage and disorganization.

7.3(6) Copying. A reasonable number of copies of an open record may be made in the agency's office. If photocopy equipment is not available in the agency office where an open record is kept, the custodian shall permit its examination in that office and shall arrange to have copies promptly made elsewhere.

7.3(7) Fees.

a. When charged. The agency may charge fees in connection with the examination or copying of records only if the fees are authorized by law. To the extent permitted by applicable provisions of law, the payment of fees may be waived when the imposition of fees is inequitable or when a waiver is in the public interest.

b. Copying and postage costs. Price schedules for published materials and for photocopies of records supplied by the agency shall be prominently posted in agency offices. Copies of records may be made by or for members of the public on agency photocopy machines or from electronic storage systems at cost as determined and posted in agency offices by the custodian. When the mailing of copies of records is requested, the actual costs of such mailing may also be charged to the requester.

c. Search and supervisory fees. Fees may be charged for actual agency expenses in searching for and supervising the examination and copying of requested records. The custodian shall notify the requester of the hourly fees to be charged for searching for records and supervision of records during examination and copying. That hourly fee shall not be in excess of the hourly wage of an agency employee who ordinarily would be appropriate and suitable to perform these search and supervisory functions.

d. Advance deposits.

(1) When the estimated total fee chargeable under this subrule exceeds \$25, the custodian may require a requester to make an advance payment to cover all or a part of the estimated fee.

(2) When a requester has previously failed to pay a fee chargeable under this subrule, the custodian may require payment of the full amount of any fees previously owed and of any estimated fees for the new request prior to processing any new request from the requester.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.4(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination. The custodian may treat a record as a confidential record and withhold it from examination only to the extent that the custodian is authorized by Iowa Code section 22.7, another applicable provision of law, or a court order, to refuse to disclose that record to members of the public.

7.4(1) Persons who may request. Any person who would be aggrieved or adversely affected by disclosure of a record and who asserts that Iowa Code section 22.7, another applicable provision of law, or a court order, authorizes the custodian to treat the record as a confidential record, may request the custodian to treat that record as a confidential record and to withhold it from public inspection.

7.4(2) Request. A request that a record be treated as a confidential record and be withheld from public inspection shall be in writing and shall be filed with the custodian. The request must set forth the legal and factual basis justifying such confidential record treatment for that record, and the name, address, and telephone number of the person authorized to respond to any inquiry or action of the custodian concerning the request. A person requesting treatment of a record as a confidential record may also be required to sign a certified statement or affidavit enumerating the specific reasons justifying the treatment of that record as a confidential record and to provide any proof necessary to establish relevant facts. Requests for treatment of a record as such a confidential record for a limited time period shall also specify the precise period of time for which that treatment is requested.

A person filing such a request shall, if possible, accompany the request with a copy of the record in question from which those portions for which such confidential record treatment has been requested

have been deleted. If the original record is being submitted to the agency by the person requesting such confidential treatment at the time the request is filed, the person shall indicate conspicuously on the original record that all or portions of it are confidential.

7.4(3) Failure to request. Failure of a person to request confidential record treatment for a record does not preclude the custodian from treating it as a confidential record. However, if a person who has submitted business information to the agency does not request that it be withheld from public inspection under Iowa Code section 22.7(3) or 22.7(6), the custodian of records containing that information may proceed as if that person has no objection to its disclosure to members of the public.

7.4(4) Timing of decision. A decision by the custodian with respect to the disclosure of a record to members of the public may be made when a request for its treatment as a confidential record that is not available for public inspection is filed, or when the custodian receives a request for access to the record by a member of the public.

7.4(5) Request granted or deferred. If a request for such confidential record treatment is granted, or if action on such a request is deferred, a copy of the record from which the matter in question has been deleted and a copy of the decision to grant the request or to defer action upon the request will be made available for public inspection in lieu of the original record. If the custodian subsequently receives a request for access to the original record, the custodian will make reasonable and timely efforts to notify any person who has filed a request for its treatment as a confidential record that is not available for public inspection of the pendency of that subsequent request.

7.4(6) Request denied and opportunity to seek injunction. If a request that a record be treated as a confidential record and be withheld from public inspection is denied, the custodian shall notify the requester in writing of that determination and the reasons therefor. On application by the requester, the custodian may engage in a good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief under the provisions of Iowa Code section 22.8, or other applicable provision of law. However, such a record need not be withheld from public inspection for any period of time if the custodian determines that the requester had no reasonable grounds to justify the treatment of that record as a confidential record. The custodian shall notify the requester in writing of the time period allowed to seek injunctive relief or the reasons for the determination that no reasonable grounds exist to justify the treatment of that record as a confidential record. The custodian may extend the period of good faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief only if no request for examination of that record has been received, or if a court directs the custodian to treat it as a confidential record, or to the extent permitted by another applicable provision of law, or with the consent of the person requesting access.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.5(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records. Except as otherwise provided by law, a person may file a request with the custodian to review, and to have a written statement of additions, dissents, or objections entered into, a record containing personally identifiable information pertaining to that person. However, this does not authorize a person who is a subject of such a record to alter the original copy of that record or to expand the official record of any agency proceeding. The requester shall send the request to review such a record or the written statement of additions, dissents, or objections to the custodian or to the Iowa law enforcement academy. The request to review such a record or the written statement of such a record of additions, dissents or objections must be dated and signed by the requester, and shall include the current address and telephone number of the requester or the requester's representative.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.6(17A,22) Access to confidential records. Under Iowa Code section 22.7 or other applicable provisions of law, the lawful custodian may disclose certain confidential records to one or more members of the public. Other provisions of law authorize or require the custodian to release specified confidential records under certain circumstances or to particular persons. In requesting the custodian to permit the examination and copying of such a confidential record, the following procedures apply and are in addition to those specified for requests for access to records in rule 501—7.3(17A,22).

7.6(1) Proof of identity. A person requesting access to a confidential record may be required to provide proof of identity or authority to secure access to the record.

7.6(2) Requests. The custodian may require that a request to examine and copy a confidential record be in writing. A person requesting access to such a record may be required to sign a certified statement or affidavit enumerating the specific reasons justifying access to the confidential record and to provide any proof necessary to establish relevant facts.

7.6(3) Notice to subject of record and opportunity to obtain injunction. After the custodian receives a request for access to a confidential record, and before the custodian releases such a record, the custodian may make reasonable efforts to notify promptly any person who is a subject of that record, is identified in that record, and whose address or telephone number is contained in that record. To the extent such a delay is practicable and in the public interest, the custodian may give the subject of such a confidential record to whom notification is transmitted a reasonable opportunity to seek an injunction under Iowa Code section 22.8, and indicate to the subject of the record the specific period of time during which disclosure will be delayed for that purpose.

7.6(4) Request denied. When the custodian denies a request for access to a confidential record, the custodian shall promptly notify the requester. If the requester indicates to the custodian that a written notification of the denial is desired, the custodian shall promptly provide such a notification that is signed by the custodian and that includes:

- a. The name and title or position of the custodian responsible for the denial; and
- b. A citation to the provision of law vesting authority in the custodian to deny disclosure of the record and a brief statement of the reasons for the denial to this requester.

7.6(5) Request granted. When the custodian grants a request for access to a confidential record to a particular person, the custodian shall notify that person and indicate any lawful restrictions imposed by the custodian on that person's examination and copying of the record.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.7(17A,22) Notice to suppliers of information. The agency shall notify persons completing agency forms of the use that will be made of personal information, which persons outside the agency might routinely be provided this information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information requested. This notice may be given in these rules, on the form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, verbally, or by other appropriate means. Notice need not be given in connection with discovery requests in litigation or administrative proceedings, subpoenas, investigations of possible violations of law, or similar demands for information.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.8(17A,22) Disclosures without the consent of the subject.

7.8(1) Open records are routinely disclosed without the consent of the subject.

7.8(2) To the extent allowed by law, disclosure of confidential records may occur without the consent of the subject. Following are instances where disclosure, if lawful, will generally occur without notice to the subject:

a. For a routine use as defined in rule 501—7.9(17A,22) or in any notice for a particular record system.

b. To a recipient who has provided the agency with advance written assurance that the record will be used solely as a statistical research or reporting record, provided that the record is transferred in a form that does not identify the subject.

c. To another government agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if an authorized representative of such government agency or instrumentality has submitted a written request to the agency specifying the record desired and the law enforcement activity for which the record is sought.

- d.* To an individual pursuant to a showing of compelling circumstances affecting the health or safety of any individual if a notice of the disclosure is transmitted to the last-known address of the subject.
- e.* To the legislative services agency under Iowa Code section 2A.3.
- f.* Disclosures in the course of employee disciplinary proceedings.
- g.* In response to a court order or subpoena.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.9(17A,22) Routine use.

7.9(1) Defined. “Routine use” means the disclosure of a record without the consent of the subject or subjects, for a purpose which is compatible with the purpose for which the record was collected. It includes disclosures required to be made by statute other than the public records law, Iowa Code chapter 22.

7.9(2) To the extent allowed by law, the following uses are considered routine uses of all agency records:

- a.* Disclosure to those officers, employees, and agents of the agency who have a need for the record in the performance of their duties. The custodian of the record may, upon request of any officer or employee, or on the custodian’s own initiative, determine what constitutes legitimate need to use confidential records.
- b.* Disclosure of information indicating an apparent violation of the law to appropriate law enforcement authorities for investigation and possible criminal prosecution, civil court action, or regulatory order.
- c.* Disclosure to the department of inspections and appeals for matters in which it is performing services or functions on behalf of the agency.
- d.* Transfers of information within the agency, to other state agencies, or to local units of government as appropriate to administer the program for which the information is collected.
- e.* Information released to staff of federal and state entities for audit purposes or for purposes of determining whether the agency is operating a program lawfully.
- f.* Any disclosure specifically authorized by the statute under which the record was collected or maintained.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.10(17A,22) Consensual disclosure of confidential records. To the extent permitted by any applicable provision of law, a person who is the subject of a confidential record may have a copy of the portion of that record concerning the subject disclosed to a third party. A request for such a disclosure must be in writing and must identify the particular record or records that may be disclosed, and the particular person or class of persons to whom the record may be disclosed (and, where applicable, the time period during which the record may be disclosed). The person who is the subject of the record and, where applicable, the person to whom the record is to be disclosed, may be required to provide proof of identity. (Additional requirements may be necessary for special classes of records.) Appearance of counsel on behalf of a person who is the subject of a confidential record is deemed to constitute consent for the agency to disclose records about that person to the person’s attorney.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.11(17A,22) Release to subject.

7.11(1) The subject of a confidential record may file a written request to review confidential records about that person as provided in rule 501—7.5(17A,22). However, the agency need not release the following records to the subject:

- a.* The identity of a person providing information to the agency need not be disclosed directly or indirectly to the subject of the information when the information is authorized to be held confidential pursuant to Iowa Code section 22.7(18) or other provision of law.
- b.* Records need not be disclosed to the subject when they are the work product of an attorney or are otherwise privileged.

- c. Peace officers' investigative reports may be withheld from the subject, except as required by the Iowa Code. (See Iowa Code section 22.7(5).)
- d. Examination may be withheld as defined in Iowa Code section 22.7(19).
- e. Decertification requests or information concerning decertification procedures under Iowa Code section 80B.13(8) and 501—Chapter 6.
- f. As otherwise authorized by law.

7.11(2) Where a record has multiple subjects with interest in the confidentiality of the record, the agency may take reasonable steps to protect confidential information relating to another subject.
[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.12(17A,22) Availability of records.

7.12(1) General. Agency records are open for public inspection and copying unless otherwise provided by rule or law.

7.12(2) Confidential records. The following records may be withheld from public inspection. Records are listed by category according to the legal basis for withholding them from public inspection.

- a. Sealed bids received prior to the time set for public opening of bids. (Iowa Code section 72.3)
- b. Tax records made available to the agency. (Iowa Code sections 422.20 and 422.72)
- c. Records which are exempt from disclosure under Iowa Code section 22.7.
- d. Minutes or audio recordings of closed meetings of a government body. (Iowa Code section 21.5(5))
- e. Identifying details in final orders, decisions and opinions to the extent required to prevent a clearly unwarranted invasion of personal privacy or trade secrets under Iowa Code section 17A.3(1) "e."
- f. Those portions of agency staff manuals, instructions or other statements issued which set forth criteria or guidelines to be used by agency staff in auditing, in making inspections, in settling commercial disputes or negotiating commercial arrangements; or in the selection or handling of cases such as operational tactics or allowable tolerances, or criteria for the defense, prosecution or settlement of cases when disclosure of these statements would:
 - (1) Enable law violators to avoid detection;
 - (2) Facilitate disregard of requirements imposed by law; or
 - (3) Give a clearly improper advantage to persons who are in an adverse position to the agency. (See Iowa Code sections 17A.2(11) "f" and 17A.3(1) "d.")
- g. Records which constitute attorney work product, attorney-client communications, or which are otherwise privileged. Attorney work product is confidential under Iowa Code sections 22.7(4), 622.10 and 622.11, state and federal rules of evidence or procedure, the Code of Professional Responsibility, and case law.
- h. Examinations and results. (Iowa Code section 22.7(19))
- i. Agency instructional outlines when disclosure would be prohibited by Iowa Code section 17A.2(11) "f."
- j. Criminal investigative reports. (Iowa Code section 22.7(5))
- k. Computer resource security files containing names, identifiers, and passwords of users of computer resources. Such files must be kept confidential to maintain security for access to confidential records pursuant to Iowa Code section 22.7. (Iowa Code section 22.7(50))
- l. Data or information collected for the purpose of assessing, analyzing, measuring, preparing for, or responding to suspected, potential, or actual information security threats. (Iowa Code section 22.7(50))
- m. Detailed security audit information. Such information includes but is not limited to security assessment reports; information directly related to vulnerability assessments; information contained in records relating to security measures such as security and response plans, security codes and combinations, passwords, restricted area passes, keys, and security or response procedures; emergency response protocols; and information contained in records that if disclosed would significantly increase the vulnerability of critical physical systems or infrastructures of the office. (Iowa Code section 22.7(50))

n. Information security data, information security proposals, or information security assessments compiled, prepared, or developed by a governmental body, or compiled, prepared, or developed by a nongovernment body and used by a government body pursuant to a contractual relationship with the nongovernment body. (Iowa Code section 22.7(50))

o. Data processing software, as defined in Iowa Code section 22.3A, which is developed by a government body, or developed by a nongovernment body and used by a government body pursuant to a contractual relationship with the nongovernment body. (Iowa Code section 22.3A(2) “a”)

p. Log-on identification passwords, Internet protocol addresses, private keys, or other records containing information which might lead to the disclosure of private keys used in a digital signature or other similar technologies as provided in Iowa Code chapter 554D.

q. Records which if disclosed might jeopardize the security of an electronic transaction pursuant to Iowa Code chapter 554D.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.13(17A,22) Personally identifiable information. This rule describes the nature and extent of personally identifiable information which is collected, maintained, and retrieved by the agency by personal identifier in a records system as defined in rule 501—7.1(17A,22). Unless otherwise stated, the authority for the Iowa law enforcement academy to maintain the record is provided by Iowa Code chapter 80B, the statutes governing the subject matter of the record.

For each record system, this rule describes the legal authority for the collection of that information, the means of storage of that information, and indicates whether a data processing system matches, collates, or permits the comparison of personally identifiable information in one record system with personally identifiable information in another record system. The record systems maintained by the agency are:

7.13(1) Law enforcement officer personal files. The Iowa law enforcement academy is charged by Iowa Code chapter 80B to establish training and hiring standards and to certify individuals as law enforcement officers in the state of Iowa. Training records, law enforcement officer status, and personal questionnaires are necessary to accomplish the mandate of Iowa Code chapter 80B.

These personal files contain information about past and present law enforcement officers in the state. These files may contain hiring and termination information, personal questionnaires and status changes (required by rule 501—3.1(80B) and rule 501—3.2(80B)), medical information showing compliance with rule 501—2.1(80B) and rule 501—2.2(80B) as authorized by Iowa Code section 80B.11, criminal history data, restoration of citizenship records, pardon records, training records, test scores, disciplinary reports and evaluation reports prepared during recruit training, decertification requests, and investigative reports. These files may also contain published articles concerning an individual officer and other data relevant to a law enforcement officer’s career in law enforcement. Some of these records may be confidential under Iowa Code section 22.7 or Iowa Code chapter 692. Law enforcement officer personal records are stored in both paper and computerized form.

7.13(2) Decertification files. These files are maintained pursuant to Iowa Code section 80B.13(8). These files contain requests or inquiries made by hiring authorities concerning decertification of a person who is certified as a law enforcement officer in the state of Iowa. The Iowa law enforcement academy also has independent authority pursuant to Iowa Code section 80B.13(8) to revoke a law enforcement officer’s certification for conviction of a felony or revoke or suspend a law enforcement officer’s certification for a violation of rules adopted pursuant to Iowa Code section 80B.11(1) “h.” These files may contain official administrative or court filings or records, investigative reports, criminal history data, and attorney-client work product concerning possible or impending litigation. Some of this information may be confidential under Iowa Code sections 17A.2 and 22.7, Iowa Code chapter 692, constitutional restraints, statute and the Code of Professional Responsibility. Except as previously noted, administrative hearing filings or records and court records or filings are public records. This information is stored in paper and computerized forms.

7.13(3) Litigation files. These files or records contain information regarding litigation, or anticipated litigation, which includes judicial and administrative proceedings. The records include

briefs, depositions, docket sheets, documents, correspondence, attorneys' notes, memoranda, research materials, witness information, investigation materials, information compiled under the direction of the attorney, and case management records. The files contain materials which are confidential as attorney work product and attorney-client communications. Some materials are confidential under other applicable provisions of law or because of a court order. Persons wanting to obtain copies of pleadings and other documents filed in litigation should obtain these from the clerk of the appropriate court which maintains the official copy. Copies of pleadings and other documents filed in litigation with the Iowa law enforcement academy may be obtained from the Iowa law enforcement academy during normal business hours as these documents are public records. These records are maintained in paper and computerized forms.

7.13(4) *Personnel files.* The agency maintains files containing information about present and former employees, families and dependents, and applicants for positions with the agency. These files include payroll records, attendance records, psychological testing results, biographical information, background investigative reports and fingerprint checks, medical information relating to disability, performance reviews and evaluations, disciplinary information, information required for tax withholding, information concerning employee benefits, affirmative action reports, and other information concerning the employer-employee relationship. Some of this information is confidential under Iowa Code sections 22.7(7) and 22.7(11) and chapter 692.

7.13(5) *Library user files.* These files contain information on individuals who have checked out books, films, tapes, etc. from the Iowa law enforcement academy library. This information is confidential pursuant to Iowa Code section 22.7(13). This information is kept in paper form and may appear in computerized form.

7.13(6) *Law enforcement class files.* These files contain information concerning individuals who have attended training classes established by the Iowa law enforcement academy. These files may contain grade information, class rosters, class schedules, class tests, photographs of class members, and disciplinary information. Some of this information may be confidential pursuant to Iowa Code section 22.7. This information is kept in computerized and paper form.

7.13(7) *Implied consent training files.* These files contain information concerning those officers who are certified to invoke implied consent pursuant to Iowa Code chapter 321J. These files are public records and are accessible during normal working hours. Some of this information may be confidential pursuant to Iowa Code section 22.7. This information is kept in computerized and paper form.

7.13(8) *Specialized instructor files.* These files contain information concerning individuals who have attended specialized training programs or through experience are qualified to instruct in specialized areas of law enforcement. These records may be retrieved by personal identifier or through class name. Some of this information may be confidential pursuant to Iowa Code section 22.7. These records are kept in both computerized and paper form.

7.13(9) *Psychological testing.* These files contain information concerning a law enforcement applicant's test scores regarding cognitive and personality tests mandated by Iowa Code section 80B.11(1) "g." In these files other psychological examinations requested by hiring agencies are also stored by a personal identifier. Some of this information may be confidential pursuant to Iowa Code section 22.7(19). Law enforcement officers interested in the results of their psychological testing should contact the hiring agency that authorized the testing. This information is maintained in both computerized and paper form.

7.13(10) *Contract file.* This file contains information concerning contracts between the Iowa law enforcement academy and outside agencies or individuals. Some of this information may be confidential pursuant to Iowa Code section 22.7(6). These records are kept in paper form or computerized form.

7.13(11) *Salary files.* These files contain information concerning financial data regarding payments made to permanent or temporary employees of the Iowa law enforcement academy. These records are maintained concurrently by the Iowa law enforcement academy, the Iowa department of administrative services, and the Iowa department of revenue. These records are kept in paper and computerized form.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.14(17A,22) Other groups of records. This rule describes groups of records maintained by the agency other than a record system as defined in rule 501—7.1(17A,22). These records are routinely available to the public; however, the agency's files of these records may contain confidential information as discussed in rule 501—7.12(17A,22). The records listed may contain information about individuals. All records are stored on paper and in computer systems unless otherwise noted.

7.14(1) Council records. Agendas, minutes, and materials presented to the Iowa law enforcement academy council are available at the Iowa law enforcement academy, except those records concerning executive sessions which are exempt from disclosure under Iowa Code section 21.5 or which are otherwise confidential by law. Council records contain information about people who participate in meetings. This information is collected pursuant to Iowa Code section 21.5.

7.14(2) Administrative records. This includes documents concerning budget, property inventory, reservation and use of facility space, purchasing, yearly reports, office policies for employees, time sheets, printing and supply requisitions, and income sources such as psychological testing fees, petty cash, tuition, film rentals, and room rentals.

7.14(3) Publications. The office receives a number of books, periodicals, videotapes, films, newsletters, government documents, etc. These records are maintained in the library established pursuant to Iowa Code section 80B.15 for use by law enforcement training centers and institutions who have a two-year program in law enforcement. Some of these records may be protected by copyright law. Many of these publications of general interest are available in the state law library.

7.14(4) Rule-making records. Public documents generated during the promulgation of agency rules, including notices and public comments, are available for public inspection.

7.14(5) Office manuals. Information in office manuals such as the instructor outlines or policy manuals may be confidential under Iowa Code section 17A.2(11) "f" or other applicable provision of law.

7.14(6) Office publications. The agency maintains statistical reports and other written documentation to educate the public about the Iowa law enforcement academy to be used in program planning and budget projections.

7.14(7) Legislative files. These files keep a record of bills being considered by the Iowa legislature each legislative session. These records are public records and can best be obtained by contacting the Iowa house or senate bill room at the state capitol.

7.14(8) Research files. These files are kept as working files to research and scrutinize different concerns particular to law enforcement and the academy's training and rule-making obligations. Some of this information is confidential as attorney-client work product, as under Iowa Code section 17A.2 or 22.7, or other applicable provisions of law.

7.14(9) All other records. Records are open if not exempted from disclosure by law.
[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—7.15(17A,22) Data processing systems. None of the data processing systems used by the agency compare personally identifiable information in one record system with personally identifiable information in another record system.

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

These rules are intended to implement Iowa Code chapters 17A and 22.

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CHAPTER 8
MANDATORY IN-SERVICE TRAINING REQUIREMENTS

501—8.1(80B) Minimum in-service training requirements. All regular law enforcement officers shall meet the following mandatory minimum in-service training requirements.

8.1(1) Firearms training. A regular law enforcement officer must qualify with all duty firearms annually on a course of fire using targets approved by the Iowa law enforcement academy and must successfully fire a minimum score as established by the Iowa law enforcement academy. This subrule applies to only those law enforcement officers who are authorized to carry firearms by the officers' employing agency.

8.1(2) CPR training. A regular law enforcement officer shall maintain current course completion in cardiopulmonary resuscitation, AED and Foreign Body Airway Obstruction for all age groups according to national standards recognized by the Iowa law enforcement academy.

8.1(3) General training. In addition to the requirements of subrules 8.1(1) and 8.1(2), a regular law enforcement officer must receive a minimum of 12 hours per year, or 36 hours every three years, of law enforcement related in-service training. Whether training is law enforcement related shall be determined by the employing agency administrator.

8.1(4) Mental health training. In addition to the requirements of subrules 8.1(1), 8.1(2) and 8.1(3), a regular law enforcement officer must receive mental health in-service training from a course of study approved by the Iowa law enforcement academy.

a. Initial in-service training. Effective September 25, 2013, each regular law enforcement officer shall complete within one year a minimum of 4 hours of mental health training from a course of study approved by the Iowa law enforcement academy council. Successful completion of Mental Health First Aid or Crisis Intervention (Memphis Model or similar model) training after January 1, 2011, shall satisfy the initial requirement.

b. Annual in-service training. Effective September 25, 2013, each regular law enforcement officer shall complete a minimum of 1 hour per year, or 4 hours every four years, of mental health training from a course of study approved by the Iowa law enforcement academy council. This annual in-service training is separate from and in addition to any other in-service training requirements set forth in this chapter, including the initial in-service mental health training required in paragraph 8.1(4) "a."

8.1(5) Mandatory reporter training.

a. Pursuant to Iowa Code sections 232.69(1) "b"(11) and 232.69(3) "b," a peace officer shall complete at least two hours of additional child abuse identification and reporting training every three years. If the peace officer completes at least one hour of additional child abuse identification and reporting training prior to the three-year expiration period, the peace officer shall be deemed in compliance with the training requirements of this rule for an additional three years.

b. Pursuant to Iowa Code sections 235B.3(2) "b" and 235B.16(5) "b," a peace officer shall complete at least two hours of additional dependent adult abuse identification and reporting training every three years. If the peace officer completes at least one hour of additional dependent adult abuse identification and reporting training prior to the three-year expiration period, the peace officer shall be deemed in compliance with the training requirements of this rule for an additional three years.

c. The elected or appointed official designated as the head of the agency employing the regular law enforcement officer shall ensure compliance with the training requirements of this subrule. The core training curriculum relating to the identification and reporting of child abuse or dependent adult abuse shall be developed and provided by the department of human services.

d. A child abuse or dependent adult abuse training certificate relating to the identification and reporting of child abuse or dependent adult abuse issued prior to July 1, 2019, remains effective and continues in effect as issued for the five-year period following its issuance.

[ARC 0962C, IAB 8/21/13, effective 9/25/13; ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—8.2(80B) Instructors.

8.2(1) A peace officer instructor who instructs in a law enforcement related training area, as determined by the law enforcement agency administrator, may receive hour-for-hour credit towards the in-service training requirement for the subject taught, plus the corresponding hours for preparation of the subject, not to exceed the credit obtained for the actual number of hours taught. An instructor in a 12-month period may receive credit for up to 12 hours of instruction for each subject taught.

8.2(2) A peace officer instructor may receive in-service training credit for the same subject taught only once every three years.

8.2(3) In-service training programs, specialized classes, or other courses of instruction that are not Iowa law enforcement academy instructor certifying schools, may be developed and instructed by any individual deemed qualified by the law enforcement agency administrator.

501—8.3(80B) Agency responsibilities regarding in-service training.

8.3(1) It is the responsibility of the law enforcement agency administrator to ensure that in-service training records are regularly kept and maintained. The law enforcement administrator shall also see that these records are made available for inspection upon request by the Iowa law enforcement academy or its designee.

8.3(2) In-service training records shall include the following data:

- a. The subject matter of the training.
- b. The instructor of the training.
- c. The individual who took the training.
- d. The number of credit hours received from the training.
- e. The location where the training took place.
- f. The scores, if any, achieved by the officer to show proficiency in or understanding of the subject matter.

8.3(3) It shall be the responsibility of the law enforcement agency administrators to ensure that all regular law enforcement officers under their direction receive the minimum hours of in-service training required by these rules.

501—8.4(80B) In-service training requirements for former regular law enforcement officers who return to law enforcement.

8.4(1) Any individual who leaves and then returns to an Iowa law enforcement officer position must receive, within one year of the individual's hiring date, in-service training as follows:

<u>Period Outside of Iowa Law Enforcement</u>	<u>In-Service Training Required</u>
6 months to 12 months	12 hours
more than 12 months to 24 months	24 hours
more than 24 months to 36 months	36 hours
more than 36 months	60 hours

8.4(2) A regular law enforcement officer must possess, or obtain within the first year of employment, CPR certification and firearms qualification as designated by the Iowa law enforcement academy, in addition to the other in-service training requirements of these rules.

8.4(3) With the approval of the law enforcement agency administrator, college credits earned during the period of required training which relate directly to law enforcement may be used to satisfy the in-service training requirement. Credit will be given on the basis of ten hours of in-service training credit for each acceptable college credit earned.

8.4(4) For currently certified officers the required three-year in-service training period will begin on the anniversary date of receipt of the initial certification which follows the effective date of the rule.

8.4(5) For officers who are not certified on the effective date of this rule, and for officers hired after the effective date of this rule, the required in-service training period will begin on the first anniversary date of their initial certification.

501—8.5(80B) Time frame—tolled. The time frame requirements for completion of any mandatory training are tolled during the period a law enforcement officer is called to active military service.

These rules are intended to implement Iowa Code section 80B.11.

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CHAPTER 10
RESERVE PEACE OFFICERS

DIVISION I
RESERVE PEACE OFFICER WEAPONS CERTIFICATION

501—10.1(80D) Weapons certification.

10.1(1) Reserve officers must receive council certification in the use of weapons the hiring authority expects and authorizes them to carry. Weapons training is not required with any weapons the reserve officers are not authorized to carry.

10.1(2) Individuals who have been certified through training by the Iowa law enforcement academy as regular officers may be certified to carry weapons as reserve officers without repeating the required reserve officer's weapons training under the following conditions:

a. The academy certification through training was acquired through a school in which firearms training was required; and

(1) The individual is serving as a regular officer for another department at the time of appointment as a reserve officer, or

(2) The individual has served as a regular officer within the two years immediately preceding appointment as a reserve officer.

b. Verification must also be provided to the council that the officer has fired a qualifying score of 80 percent or higher on a firearm course using targets approved by the academy within the past 12 months. This verification must be provided by an academy-trained and -certified firearms instructor.

10.1(3) Application for weapons certification.

a. Application for weapons certification must be made in writing to the council on forms provided by the academy.

b. Verification must be received by the council that a fingerprint check has been made with the Federal Bureau of Investigation and the division of criminal investigation of the Iowa department of public safety and that the applicant has not been convicted or adjudicated of any offense listed in 501—paragraph 2.1(5) "a." Fingerprint check responses from these agencies must be dated not more than one year prior to the date of the receipt by the academy of the application to the council for certification.

c. Council certification will be granted only where weapons proficiency is documented.

d. Interim certification to carry weapons may be granted by the chairperson of the council if all requirements for certification have been met by the reserve officer and certified by the appointing authority. All interim certifications to carry weapons shall then be brought before the council at the next regularly scheduled meeting in order that the council can approve or reject the reserve officer's certification to carry weapons.

[ARC 0962C, IAB 8/21/13, effective 9/25/13; ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—10.2(80D) Instructors for required weapons training. Firearms, striking instruments and chemical weapons training must be provided by an Iowa law enforcement academy-certified instructor before a reserve officer can be certified to carry weapons.

501—10.3(80D) Reserve officers and regular officers weapons training requirements identical. Reserve officer weapons training requirements are the same as those required of regular law enforcement officers during their basic training.

501—10.4(80D) Standards for certification. An applicant for certification to carry weapons as a reserve peace officer must be of good moral character and not have been convicted or adjudicated of any offense listed in 501—paragraph 2.1(5) "a."

[ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—10.5(80D) Annual qualification. All reserve peace officers who are certified to carry firearms must qualify with all duty firearms annually on a course of fire using targets approved by the Iowa

law enforcement academy under the supervision of an academy-certified firearms instructor and must successfully fire a minimum score as established by the academy.

[ARC 0962C, IAB 8/21/13, effective 9/25/13]

501—10.6(80D) Agency responsibilities for record keeping.

10.6(1) It is the responsibility of the law enforcement agency administrator to ensure that training records are regularly kept and maintained. The law enforcement administrator shall make these records available for inspection upon request by the Iowa law enforcement academy or its designee.

10.6(2) Training records shall include the following data:

- a. The date of the training.
- b. The subject matter of the training.
- c. The instructor of the training.
- d. The individual who took the training.
- e. The length of time of the training.
- f. The location where the training took place.
- g. Qualifying range scores and the scores, if any, achieved by the officer to show proficiency in or understanding of the subject matter.

501—10.7(80D) Officers transferring from one agency to another. A reserve peace officer who has been certified by the Iowa law enforcement academy council to carry weapons and who transfers from one Iowa law enforcement agency to another as a reserve officer without more than a 180-day break in service (affiliation) will not be required to undergo weapons certification training anew, provided that a completed application to carry weapons as a reserve officer for the new agency in compliance with Iowa Code section 80D.7 is filed with the academy within 180 days of the date of transfer. If firearms certification is requested, the application must show that the officer has fired qualifying rounds under the supervision of an ILEA-certified firearms instructor within 30 days of the date of application. The application shall further state that all training records for the officer have been transcribed to the new agency.

501—10.8(80D) Reserve peace officers serving more than one agency. A reserve peace officer who serves more than one Iowa law enforcement agency at the same time must be certified by the Iowa law enforcement academy council to carry weapons for each agency that the reserve officer serves in compliance with Iowa Code section 80D.7. It is not necessary for the officer to complete weapons training for each such agency, but all agencies shall maintain duplicate training records for the officer.

501—10.9(80D) Timeliness of training. Training in support of an application to the Iowa law enforcement academy council to carry weapons as a reserve peace officer shall have been accomplished not more than one year prior to the date of the receipt by the academy of the application to the council for certification. Failure to file the application within one year of the date of training shall require the officer to undergo weapons training anew.

501—10.10(80D) CPR certification required. Reserve peace officers shall maintain current course completion in cardiopulmonary resuscitation, AED and foreign body airway obstruction for all age groups according to national standards recognized by the Iowa law enforcement academy.

[ARC 3997C, IAB 9/12/18, effective 10/17/18]

501—10.11 to 10.99 Reserved.

These rules are intended to implement Iowa Code sections 80D.3 and 80D.7.

DIVISION II
RESERVE PEACE OFFICER PERSONAL STANDARDS

501—10.100(80D) General requirements for reserve peace officers. In no case shall any person hereafter be selected or appointed as a reserve peace officer unless the person:

10.100(1) Is a citizen of the United States and a resident of Iowa or intends to become a resident of Iowa upon appointment as a reserve peace officer; provided that the state residency requirement under this subrule shall not apply to employees of a city or county that has adopted an ordinance to allow the employees of the city or county to reside in another state and shall not apply to an employee of a city or county that later repeals such an ordinance if the employee resides in another state at the time of the repeal. A city or county that has adopted an ordinance to allow the employees of the city or county to reside in another state shall provide a current copy of the ordinance to the Iowa law enforcement academy.

10.100(2) Is 18 years of age at the time of selection or appointment.

10.100(3) Has a valid driver's or chauffeur's license issued by the state of Iowa. Reserve peace officers who are allowed to reside in an adjacent state shall be required to possess a valid driver's or chauffeur's license of the state of residence of the officer.

10.100(4) Is not addicted to drugs or alcohol.

10.100(5) Is of good moral character as determined by a thorough background investigation including a fingerprint search conducted on local, state and national fingerprint files, and has not been convicted or adjudicated of any offense listed in 501—paragraph 2.1(5) "a."

10.100(6) Is not by reason of conscience or belief opposed to the use of force when necessary to fulfill the person's duties.

10.100(7) Is a high school graduate with a diploma, or possesses a GED equivalency certificate.

10.100(8) Has an uncorrected vision of not less than 20/100 in both eyes, corrected to 20/20.

The applicant shall have color vision consistent with the occupational demands of law enforcement. An applicant's passing any of the following color vision tests indicates that the applicant has color vision abilities consistent with the occupational demands of law enforcement:

a. Pseudoisochromatic plates tests such as but not limited to: Tokyo Medical College, Ishihara, Standard Pseudoisochromatic Plates, Dvorine, American Optical HHR Plates, American Optical.

b. Panels tests such as Farnsworth Dichotomous D-15 Test or any other test designed and documented to identify extreme anomalous trichromatic, dichromatic or monochromatic color vision.

An individual with extreme anomalous trichromatism or monochromasy color vision, as determined through testing, is not eligible to serve as a reserve peace officer in the state of Iowa.

10.100(9) Has hearing corrected to normal hearing standards. Hearing is considered normal when, tested by an audiometer, hearing sensitivity thresholds are within 25dB measured at 1000Hz, 2000Hz and 3000Hz averaged together. Hearing tests conducted within 12 months before appointment or selection may be used. A person who performs policing duties alone and without the direct supervision of a certified regular law enforcement officer who is physically present with the reserve peace officer at all times must have normal hearing in each ear. Policing duties include but are not limited to responding to calls, making traffic stops, and patrolling the jurisdiction.

10.100(10) Is examined by a licensed physician or surgeon and meets the physical requirements as defined by the law enforcement agency necessary to fulfill the responsibilities of the reserve peace officer position being filled.

[ARC 2960C, IAB 3/1/17, effective 4/5/17; ARC 5006C, IAB 3/25/20, effective 4/29/20]

501—10.101(80D) Reserve peace officers moving from agency to agency.

10.101(1) A reserve peace officer who has previously met all the requirements of rule 501—10.100(80D) and who intends to move reserve peace officer status from one Iowa law enforcement agency to another Iowa law enforcement agency, or who intends to be a reserve peace officer for more than one Iowa law enforcement agency simultaneously, shall be of good moral character as determined by a thorough background investigation by the law enforcement agency, including, but not limited to, a fingerprint search conducted by the Iowa division of criminal investigation and the Federal Bureau of Investigation. If the results of the fingerprint file checks cannot reasonably be obtained prior to the time of appointment, the appointment shall be considered conditional until such time as the results are received and reviewed by the appointing agency.

10.101(2) Except as otherwise specified, the provisions of rule 501—10.100(80D) do not need to be reverified upon the movement of reserve peace officer status from one Iowa law enforcement agency to another Iowa law enforcement agency or upon the reserve peace officer's being appointed as a reserve peace officer by more than one Iowa law enforcement agency simultaneously, if the reserve peace officer met all of the requirements of rule 501—10.100(80D) when the person was initially appointed as a reserve peace officer and if, without a break of not more than 180 days from law enforcement service, the person is appointed as a reserve peace officer by another Iowa law enforcement agency.

501—10.102(80D) Active law enforcement officer moving to reserve peace officer status.

10.102(1) An active law enforcement officer who has previously met all the requirements of rule 501—2.1(80B) and who intends to move to reserve peace officer status, or who intends to be a reserve peace officer for more than one Iowa law enforcement agency simultaneously, or who intends to be a reserve peace officer for an Iowa law enforcement agency while also working as an active law enforcement officer shall be of good moral character as determined by a thorough background investigation by the law enforcement agency, including, but not limited to, a fingerprint search conducted by the Iowa division of criminal investigation and the Federal Bureau of Investigation. If the results of the fingerprint file checks cannot reasonably be obtained prior to the time of appointment, the appointment shall be considered conditional until such time as the results are received and reviewed by the appointing agency.

10.102(2) Except as otherwise specified, the provisions of rule 501—10.100(80D) do not need to be verified upon the movement of active law enforcement officer status to reserve peace officer status or upon the officer's being appointed as a reserve peace officer by more than one Iowa law enforcement agency simultaneously, or upon the officer's being appointed as a reserve peace officer by one Iowa law enforcement agency while serving in active law enforcement status for another agency if the peace officer met all of the requirements of rule 501—2.1(80B) when the person was initially appointed as a peace officer and if, without a break of not more than 180 days from law enforcement service, the person is appointed as a reserve peace officer by another Iowa law enforcement agency.

501—10.103(80D) Reserve peace officers in agencies under intergovernmental agreements. When jurisdictions enter into an intergovernmental agreement under the provisions of Iowa Code chapter 28E for the sharing of law enforcement services by those jurisdictions and sharing of reserve peace officers, the compliance of reserve peace officers with rule 501—10.100(80D) does not need to be reverified if the execution, filing and recording of the intergovernmental agreement conform to the requirements of Iowa law and a certified copy of the agreement is provided to the director of the academy. However, this exception from reverification does not apply to the establishment of a unified law enforcement district as defined in Iowa Code section 28E.21, wherein a new legal entity or political subdivision is established.

501—10.104(80D) Higher standards not prohibited. A person who does not meet minimum standards shall not be selected or appointed as an Iowa reserve peace officer. Agencies are not limited or restricted in establishing additional standards.

501—10.105(80D) Reserve peace officers appointed before enactment of these rules. These rules apply only to reserve peace officers appointed on or after June 2, 2004.

501—10.106 to 10.199 Reserved.

DIVISION III
RESERVE PEACE OFFICER
STANDARDIZED TRAINING AND CERTIFICATION

501—10.200(80D) Certification through training required for all reserve peace officers.

10.200(1) Each person appointed to serve as a reserve peace officer after July 1, 2007, shall satisfactorily complete a minimum training course established by the academy consisting of 80 hours of

training and 40 hours of supervised time. Training for individuals appointed as reserve peace officers shall be provided by instructors in a community college or other facility, including a law enforcement agency, selected by the individual and approved by the law enforcement agency and the academy. Reserve peace officers must be certified within 18 months from the date of their appointment.

10.200(2) The academy council may, at the council's discretion, extend the 18-month time period in which a reserve peace officer must become certified for up to 180 days after a showing of "undue hardship" by the reserve peace officer or the reserve peace officer's appointing agency. To be considered for an extension of the 18-month certification period, the person or agency requesting the extension must initiate the request in writing not less than 10 days prior to the council meeting at which the extension request is to be discussed and must also make a presentation to the council at the next regularly scheduled meeting of the council. An extension shall not be liberally granted and shall only be granted after a showing that all other alternatives to an extension have been considered and rejected.

10.200(3) The time period within which a person must achieve certification as a reserve peace officer in the state of Iowa shall commence on the day a person is first appointed as a reserve peace officer in the state of Iowa. Any subsequent changes in a reserve peace officer's appointment status, including transfers to a different appointing agency, shall not toll or otherwise extend the certification period. Those reserve peace officers appointed after July 1, 2007, but before October 3, 2007, shall have 18 months after October 3, 2007, to complete the training and supervision requirements.

10.200(4) Should a person appointed as a reserve peace officer fail to achieve certification within the time period or under any extension allowed by this rule, that person shall not be eligible for appointment as a reserve peace officer and shall not serve as a reserve peace officer in the state of Iowa for a period of not less than one year from the date the time period in which to achieve certification expired, or from the date that the person was last appointed as a reserve peace officer in the state of Iowa, whichever comes first.

501—10.201(80D) Training modules. Six modules consisting of 12 to 16 hours of required training topics per module will be developed by the academy. The training modules will include curriculum and training materials for each topic consisting of learning objectives, a lesson plan, training aids such as presentation tools, handouts, and sample tests. Curriculum and training materials will be provided by the academy to those agencies with academy-approved instructors. Training modules will be updated no less than every three years.

501—10.202(80D) Completion of training modules. The agency providing the training shall notify the academy when a training module is completed. The reserve peace officer completing the training module will be given an academy-developed test covering the completed module. The reserve peace officer completing the training module must pass the test with a score of 70 percent or better. The reserve peace officer may take the test a second time if the first test score is below 70 percent and the appointing law enforcement agency approves the second test. The reserve peace officer must then retake the training in the area failed if the second test score is below 70 percent before taking the test a third time if the appointing law enforcement agency approves the third test. Failure of the test the third time will result in the individual's not being eligible for certification for a period of one year following the date of the third test failure.

501—10.203(80D) Supervised time. Supervised time is defined as direct supervision by a regular certified law enforcement officer of the reserve peace officer while performing activities consistent with the reserve peace officer's duties, such as ride-along time, jail time, or other assigned duties.

501—10.204(80D) Certification. Upon satisfactory completion of training and supervised time required by the academy, the individual shall be certified by the academy as an Iowa reserve peace officer and shall be issued a certificate by the academy.

501—10.205(80D) Time frame—tolled. The time frame requirements for completion of any mandatory training are tolled during the period a reserve peace officer is called to active military service.

501—10.206(80D) Minimum in-service training requirements. All certified reserve peace officers shall meet the following mandatory minimum in-service training requirements.

10.206(1) Firearms training. A certified reserve peace officer who is authorized to carry firearms must qualify with all duty firearms annually on a course of fire using targets approved by the Iowa law enforcement academy and must successfully fire a minimum score as established by the Iowa law enforcement academy. This subrule applies only to those reserve peace officers who are authorized to carry firearms by the officers' appointing agency.

10.206(2) General training. In addition to the firearms training and CPR training requirements, a certified reserve peace officer must receive a minimum of 12 hours per year, or 36 hours every three years, of law enforcement-related in-service training. Whether training is law enforcement-related shall be determined by the employing agency administrator.

10.206(3) Agency responsibility. It is the responsibility of the law enforcement agency administrator to ensure that in-service training records are regularly kept and maintained. The law enforcement administrator shall also ensure that these records are made available for inspection upon request by the Iowa law enforcement academy or its designee.

a. In-service training records shall include the following:

- (1) The subject matter of the training;
- (2) The name of the instructor of the training;
- (3) The name of the individual who took the training;
- (4) The number of credit hours received from the training;
- (5) The location where the training took place; and
- (6) The scores, if any, achieved by the reserve peace officer to show proficiency in or understanding of the subject matter.

b. It shall be the responsibility of law enforcement agency administrators to ensure that all certified reserve peace officers under their direction receive the minimum hours of in-service training required by these rules.

10.206(4) Mental health training. In addition to the requirements of subrules 10.206(1) and 10.206(2), a certified reserve peace officer must receive mental health in-service training from a course of study approved by the Iowa law enforcement academy.

a. Initial in-service training. Effective September 25, 2013, each certified reserve peace officer shall complete within one year a minimum of 4 hours of mental health training from a course of study approved by the Iowa law enforcement academy council. Successful completion of Mental Health First Aid or Crisis Intervention (Memphis Model or similar model) training after January 1, 2011, shall satisfy the initial requirement.

b. Annual in-service training. Effective September 25, 2013, each certified reserve peace officer shall complete a minimum of 1 hour per year, or 4 hours every four years, of mental health training from a course of study approved by the Iowa law enforcement academy council. This annual in-service training is separate from and in addition to any other in-service training requirements set forth in this chapter, including the initial in-service mental health training required in paragraph 10.206(4) "a."

[ARC 0962C, IAB 8/21/13, effective 9/25/13]

501—10.207(80D) Training and in-service training requirements for regular law enforcement officers who become certified reserve peace officers.

10.207(1) An active certified regular law enforcement officer who also serves as a reserve peace officer or a certified regular law enforcement officer who retires or leaves active regular law enforcement and returns within 180 days to an Iowa law enforcement agency as a reserve peace officer needs no further training.

10.207(2) Any individual who leaves an Iowa law enforcement officer position and becomes a certified reserve peace officer shall receive in-service training within one year of the individual's appointment date as follows:

<u>Period Outside of Iowa Law Enforcement</u>	<u>In-Service Training Required</u>
6 months to 12 months	12 hours
More than 12 months to 24 months	24 hours
More than 24 months to 36 months	36 hours
More than 36 months	60 hours

The subject matter of this training will be determined and approved by the law enforcement agency.

501—10.208(80D) Reserve peace officers appointed prior to July 1, 2007—obtaining state certification.

10.208(1) A reserve peace officer enrolled in an approved minimum course of training prior to July 1, 2007, shall obtain state certification by July 1, 2012. The state certification may be obtained through certification by examination. Reserve peace officers who have received training prior to July 1, 2007, may, upon application to and approval from the director, take a competency test or tests to gain Iowa reserve peace officer certification. Successful completion of the required test or tests will result in certification by the council. The test or tests and study material shall be prepared and administered by the academy. The individual must pass the test or tests with a score of 70 percent or better. Individuals will be allowed to take the test or tests a second time in the areas with scores below 70 percent within 60 days and with the approval of the appointing law enforcement agency. The individual must pass the test or tests upon retake with a score of 70 percent or better. Failure to score 70 percent or better the second time will require the individual, with approval of the appointing law enforcement agency, to take the 80-hour module training established by the academy.

10.208(2) Criteria to be eligible to certify through examination. The following is required for certification through examination: successful completion of a minimum 150-hour certifying reserve peace officer training program.

10.208(3) Current reserve peace officers choosing not to be state certified by examination or by module training established by the academy will continue to hold agency certification only and will not be recognized as reserve peace officers after July 1, 2012.

10.208(4) If a reserve peace officer appointed prior to July 1, 2007, with agency certification only transfers to another agency, the reserve peace officer will be considered a new reserve peace officer and will be subject to the 18-month training requirements for state certification.

501—10.209(80D) Instructors for approved reserve peace officer training program.

10.209(1) All reserve peace officer instructors will be designated as general, specialist, or legal instructors. General law enforcement instructors will be those instructing in subjects that are clearly law enforcement in nature and as designated by the academy. Specialist law enforcement instructors are those persons who have attended specialized schools and possess considerable experience in the subject to be taught as designated by the academy. Legal instructors are those persons with a juris doctor degree instructing in the area of criminal law.

10.209(2) Request for instructional certification. All instructors requesting certification must submit this request to the academy council on an application form that can be obtained from the Iowa law enforcement academy.

10.209(3) Granting or revocation of instructor certification.

a. Instructor certification will be issued for a period of three years. Instructor certification may be renewed for a three-year period if the instructor has instructed in a reserve peace officer training program during the three-year time period; the reserve peace officer training coordinator or administrator for the agency recommends renewal of the instructor certification; the individual remains in good standing; and required certification in the specialty areas is in force and valid at the time of application.

b. Instructor certification may be revoked in writing when, in the opinion of the academy or in the opinion of the administrator of the appointing law enforcement agency or other agency requesting certification, that certification should be revoked. In the event of denial of recertification or revocation

of certification, the certificate holder may file a written notice of appeal to the academy council within 30 days of notification of the action. The appeal notice should be addressed to Director, Iowa Law Enforcement Academy, Camp Dodge, P.O. Box 130, Johnston, Iowa 50131. A hearing on the matter will be held by the academy council as soon as possible after receipt of the notice of appeal.

501—10.210(80D) Minimum qualifications for certification of general instructor. The minimum qualifications for certification of a general instructor include the following: a regular, nonprobationary Iowa certified sworn peace officer (active, inactive, or retired in good standing) with documented experience in the subject area to be instructed and endorsement by the chief, sheriff, or agency administrator of a law enforcement agency or other agency approved by the council as to the person's qualifications to instruct. Good standing is determined by the endorser and by the academy. A person who has been dismissed for good cause from previous employment, who left during an internal affairs investigation that would have resulted in dismissal for good cause, or who is currently involved in the decertification process shall not be considered in good standing.

501—10.211(80D) Minimum qualifications for certification of specialist instructor. The minimum qualifications for certification of a specialist instructor include the following.

10.211(1) The individual must have successfully completed a specialty course in the area to be instructed when required. The individual must have successfully met all requirements of the issuing agency granting the certification as an instructor in the specialty area requiring instructor certification. The specialty areas requiring certification include force management (ILEA), defensive tactics (ILEA), precision driving (ILEA), Hazmat awareness, blood-borne pathogens, and mandatory reporting. Certification from the issuing agency must be in force and valid at the time of application in order for the individual to be considered as a specialist instructor.

10.211(2) An instructor of the role of emergency communications must have completed the 40-hour basic telecommunication training approved by the academy or have been employed as a telecommunication specialist since July 1998.

10.211(3) An instructor of juvenile law must be a juvenile probation officer or department of human services social worker or be listed under "legal instructor."

10.211(4) An instructor of weather preparedness must have experience with the National Weather Service or be listed as a general instructor as defined above.

10.211(5) An instructor of current drug trends/investigations will be qualified by training and experience in drug investigations such as serving on a drug task force, attending DNE/DEA 40-hour training, or attending DRE training.

501—10.212(80D) Minimum qualifications for certification of legal instructor. The minimum qualifications for certification of a legal instructor include the following: The individual must have a juris doctor degree and be licensed to practice law in Iowa.

These rules are intended to implement Iowa Code sections 80D.1A, 80D.3, 80D.4 and 2007 Iowa Acts, Senate File 110.

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PROFESSIONAL LICENSURE DIVISION[645]

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Prior to 7/29/87, for Chs. 20 to 22 see Health Department[470] Chs. 152 to 154.

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645—20.1(272C) Definitions.

“*Board*” means a licensing board within the professional licensure division.

“*License*” or “*licensure*” means any license, registration, certificate, or permit that may be granted by a licensing board within the professional licensure division.

“*Military service*” means honorably serving on federal active duty, state active duty, or national guard duty, as defined in Iowa Code section 29A.1; in the military services of other states, as provided in 10 U.S.C. Section 101(c); or in the organized reserves of the United States, as provided in 10 U.S.C. Section 10101.

“*Military service applicant*” means an individual requesting credit toward licensure for military education, training, or service obtained or completed in military service.

“*Spouse*” means a spouse of an active duty member of the military forces of the United States.

“*Veteran*” means an individual who meets the definition of “veteran” in Iowa Code section 35.1(2).
[ARC 1833C, IAB 1/21/15, effective 2/25/15; ARC 5009C, IAB 3/25/20, effective 4/29/20]

645—20.2(272C) Military education, training, and service credit. A military service applicant may apply for credit for verified military education, training, or service toward any experience or educational requirement for licensure by submitting a military service application form to the board office.

20.2(1) The application may be submitted with an application for licensure or examination, or prior to applying for licensure or to take an examination. No fee is required for submission of an application for military service credit.

20.2(2) The applicant shall identify the experience or educational licensure requirement to which the credit would be applied if granted. Credit shall not be applied to an examination requirement.

20.2(3) The applicant shall provide documents, military transcripts, a certified affidavit, or forms that verify completion of the relevant military education, training, or service, which may include, when applicable, the applicant’s Certificate of Release or Discharge from Active Duty (DD Form 214) or Verification of Military Experience and Training (VMET) (DD Form 2586).

20.2(4) Upon receipt of a completed military service application, the board shall promptly determine whether the verified military education, training, or service will satisfy all or any part of the identified experience or educational qualifications for licensure.

20.2(5) The board shall grant credit requested in the application in whole or in part if the board determines that the verified military education, training, or service satisfies all or part of the experience or educational qualifications for licensure.

20.2(6) The board shall inform the military service applicant in writing of the credit, if any, given toward an experience or educational qualification for licensure, or explain why no credit was granted. The applicant may request reconsideration upon submission of additional documentation or information.

20.2(7) A military service applicant who is aggrieved by the board’s decision may request a contested case (administrative hearing) and may participate in a contested case by telephone. A request for a contested case shall be made within 30 days of issuance of the board’s decision. The provisions of 645—Chapter 11 shall apply, except that no fees or costs shall be assessed against the military service applicant in connection with a contested case conducted pursuant to this subrule.

20.2(8) The board shall grant or deny the military service application prior to ruling on the application for licensure. The applicant shall not be required to submit any fees in connection with the licensure application unless the board grants the military service application. If the board does not grant the military service application, the applicant may withdraw the licensure application or request that the licensure application be placed in pending status for up to one year or as mutually agreed. The withdrawal of a licensure application shall not preclude subsequent applications supported by additional documentation or information.

[ARC 1833C, IAB 1/21/15, effective 2/25/15; ARC 5009C, IAB 3/25/20, effective 4/29/20]

645—20.3(272C) Veteran and active duty military spouse reciprocity.

20.3(1) A veteran or spouse with an unrestricted professional license in another jurisdiction may apply for licensure in Iowa through reciprocity. A veteran or spouse must pass any examinations required for licensure to be eligible for licensure through reciprocity and will be given credit for examinations previously passed when consistent with board laws and rules on examination requirements. A fully completed application for licensure submitted by a veteran or spouse under this subrule shall be given priority and shall be expedited.

20.3(2) Such an application shall contain all of the information required of all applicants for licensure who hold unrestricted licenses in other jurisdictions and who are applying for licensure by reciprocity, including, but not limited to, completion of all required forms, payment of applicable fees, disclosure of criminal or disciplinary history, and, if applicable, a criminal history background check. The applicant shall use the same forms as any other applicant for licensure by reciprocity and shall additionally provide such documentation as is reasonably needed to verify the applicant's status as a veteran under Iowa Code section 35.1(2) or a spouse of an active duty member of the military forces of the United States.

20.3(3) Upon receipt of a fully completed licensure application, the board shall promptly determine if the professional or occupational licensing requirements of the jurisdiction where the applicant is licensed are substantially equivalent to the licensing requirements in Iowa. The board shall make this determination based on information supplied by the applicant and such additional information as the board may acquire from the applicable jurisdiction. As relevant to the license at issue, the board may consider the following factors in determining substantial equivalence: scope of practice, education and coursework, degree requirements, postgraduate experience, and examinations required for licensure.

20.3(4) The board shall promptly grant a license to the applicant if the applicant is licensed in the same or similar profession in another jurisdiction whose licensure requirements are substantially equivalent to those required in Iowa, unless the applicant is ineligible for licensure based on other grounds, for example, the applicant's disciplinary or criminal background.

20.3(5) If the board determines that the licensing requirements in the jurisdiction in which the applicant is licensed are not substantially equivalent to those required in Iowa, the board shall promptly inform the applicant of the additional experience, education, or examinations required for licensure in Iowa. Unless the applicant is ineligible for licensure based on other grounds, such as disciplinary or criminal background, the following shall apply:

a. If an applicant has not passed the required examination(s) for licensure, the applicant may not be issued a provisional license, but may request that the licensure application be placed in pending status for up to one year or as mutually agreed to provide the applicant with the opportunity to satisfy the examination requirements.

b. If additional experience or education is required in order for the applicant's qualifications to be considered substantially equivalent, the applicant may request that the board issue a provisional license for a specified period of time during which the applicant will successfully complete the necessary experience or education. The board shall issue a provisional license for a specified period of time upon such conditions as the board deems reasonably necessary to protect the health, welfare or safety of the public unless the board determines that the deficiency is of a character that the public health, welfare or safety will be adversely affected if a provisional license is granted.

c. If a request for a provisional license is denied, the board shall issue an order fully explaining the decision and shall inform the applicant of the steps the applicant may take in order to receive a provisional license.

d. If a provisional license is issued, the application for full licensure shall be placed in pending status until the necessary experience or education has been successfully completed or the provisional license expires, whichever occurs first. The board may extend a provisional license on a case-by-case basis for good cause.

20.3(6) An applicant who is aggrieved by the board's decision to deny an application for a reciprocal license or a provisional license or is aggrieved by the terms under which a provisional license will be granted may request a contested case (administrative hearing) and may participate in a contested case by telephone. A request for a contested case shall be made within 30 days of issuance of the board's

decision. The provisions of 645—Chapter 11 shall apply, except that no fees or costs shall be assessed against the applicant in connection with a contested case conducted pursuant to this subrule.

[ARC 1833C, IAB 1/21/15, effective 2/25/15; ARC 5009C, IAB 3/25/20, effective 4/29/20]

These rules are intended to implement Iowa Code section 272C.4 as amended by 2019 Iowa Acts, chapter 9.

[Filed ARC 1833C (Notice ARC 1668C, IAB 10/15/14), IAB 1/21/15, effective 2/25/15]

[Filed ARC 5009C (Notice ARC 4654C, IAB 9/11/19), IAB 3/25/20, effective 4/29/20]

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CHAPTER 31
LICENSURE OF MARITAL AND FAMILY THERAPISTS,
MENTAL HEALTH COUNSELORS, BEHAVIOR ANALYSTS, AND ASSISTANT BEHAVIOR
ANALYSTS

[Prior to 1/30/02, see 645—Chapter 30]

645—31.1(154D) Definitions. For purposes of these rules, the following definitions shall apply:

“*ACA*” means the American Counseling Association.

“*Active license*” means a license that is current and has not expired.

“*AMFTRB*” means the Association of Marriage and Family Therapy Regulatory Boards.

“*AMHCA*” means the American Mental Health Counselors Association.

“*BACB*” means the Behavior Analyst Certification Board.

“*Board*” means the board of behavioral science.

“*CCE*” means the Center for Credentialing and Education, Inc.

“*Course*” means three graduate semester credit hours.

“*Department*” means the department of public health.

“*Grace period*” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*Licensee*” means any person licensed to practice as a marital and family therapist, mental health counselor, behavior analyst, or assistant behavior analyst in the state of Iowa.

“*License expiration date*” means September 30 of even-numbered years for marital and family therapists and mental health counselors, and means the expiration date of the certification issued by the Behavior Analyst Certification Board for behavior analysts and assistant behavior analysts.

“*Licensure by endorsement*” means the issuance of an Iowa license to practice mental health counseling or marital and family therapy to an applicant who is or has been licensed in another state.

“*Mandatory training*” means training on identifying and reporting child abuse or dependent adult abuse required of marital and family therapists and mental health counselors who are mandatory reporters. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69. The full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

“*Mental health setting*” means a behavioral health setting where an applicant is providing mental health services including the diagnosis, treatment, and assessment of emotional and mental health disorders and issues.

“*NBCC*” means the National Board for Certified Counselors.

“*Reactivate*” or “*reactivation*” means the process as outlined in rule 645—31.16(17A,147,272C) by which an inactive license is restored to active status.

“*Reciprocal license*” means the issuance of an Iowa license to practice mental health counseling or marital and family therapy to an applicant who is currently licensed in another state which has 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 license” means a license to practice marital and family therapy or mental health counseling under direct supervision of a qualified supervisor as determined by the board by rule to fulfill the postgraduate supervised clinical experience requirement in accordance with this chapter.

[ARC 9547B, IAB 6/1/11, effective 7/6/11; ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19; ARC 5010C, IAB 3/25/20, effective 4/29/20]

645—31.2(154D) Requirements for permanent and temporary licensure as a mental health counselor or marriage and family therapist. The following criteria shall apply to licensure:

31.2(1) The applicant shall complete a board-approved application. Application forms may be obtained from the board’s website (www.idph.iowa.gov/licensure) or directly from the board office, or the applicant may complete the application online at ibplicense.iowa.gov. All paper applications shall be sent to the Board of Behavioral Science, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

31.2(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.

31.2(3) Each application shall be accompanied by the appropriate fees payable to the Board of Behavioral Science. The fees are nonrefundable.

31.2(4) No application will be considered by the board until official copies of academic transcripts sent directly from the school to the board of behavioral science have been received by the board or an equivalency evaluation completed by the Center for Credentialing and Education, Inc. (CCE) has been received by the board. The applicant shall present proof of meeting the educational requirements. Documentation of such proof shall be on file in the board office with the application and include one of the following:

a. For licensure as a marital and family therapist, an official transcript verifying completion of a marital and family therapy program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) as defined in subrule 31.4(1) or an equivalency evaluation of the applicant’s educational credentials completed by CCE as defined in subrule 31.4(2).

b. For licensure as a mental health counselor, an official transcript verifying completion of a mental health counseling program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP) as defined in subrule 31.6(1) or an equivalency evaluation of the applicant’s educational credentials completed by CCE as defined in subrule 31.6(2).

31.2(5) The candidate for permanent licensure shall have the examination score sent directly from the testing service to the board. The candidate for temporary licensure must successfully complete the examination before the temporary license is issued.

31.2(6) The candidate for permanent licensure shall submit the required attestation of supervision forms documenting clinical experience as required in rule 645—31.5(154D) for marital and family therapy and rule 645—31.7(154D) for mental health counseling.

31.2(7) The candidate for temporary licensure for the purpose of fulfilling the postgraduate supervised clinical experience requirement must submit the Supervised Clinical Experience: Approval and Attestation form to the board and receive approval of the candidate’s supervisor(s) prior to licensure. The temporary licensee must notify the board immediately in writing of any proposed change in supervisor(s) and obtain approval of any change in supervisor(s). Within 30 days of completion of the supervised clinical experience, the attestation of the completed supervised experience must be submitted to the board office. The temporary licensee shall remain under supervision until a permanent license is issued.

31.2(8) A temporary license for the purpose of fulfilling the postgraduate supervised clinical experience requirement is valid for three years and may be renewed at the discretion of the board.

31.2(9) A licensee who was issued an initial permanent license within six months prior to the renewal shall not be required to renew the license until the renewal date two years later.

31.2(10) Submitting complete application materials. An application for a temporary or permanent license will be considered active for two years from the date the application is received. If the applicant does not submit all materials within this time period or if the applicant does not meet the requirements for the license, the application shall be considered incomplete. An applicant whose application is filed incomplete must submit a new application, supporting materials, and the application fee. The board shall destroy incomplete applications after two years.

[ARC 8152B, IAB 9/23/09, effective 10/28/09; ARC 0777C, IAB 6/12/13, effective 7/17/13; ARC 1758C, IAB 12/10/14, effective 1/14/15; ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19]

645—31.3(154D) Examination requirements for mental health counselors and marital and family therapists. The following criteria shall apply to the written examination(s):

31.3(1) The applicant shall take and pass the following examinations in order to qualify for licensing:

a. For a marital and family therapist license, the Association of Marriage and Family Therapy Regulatory Board (AMFTRB) Examination in Marital and Family Therapy.

b. Prior to January 1, 2022, for a mental health counselor license or a temporary mental health counselor license, the National Counselor Examination (NCE) of the NBCC or the National Clinical Mental Health Counselor Examination (NCMHCE) of the NBCC.

c. Effective January 1, 2022, for a temporary mental health counselor license, the NCE of the NBCC or the NCMHCE of the NBCC.

d. Effective January 1, 2022, for a mental health counselor license, the NCMHCE of the NBCC.

31.3(2) Examination information will be provided when the applicant has been approved to take the examination.

31.3(3) The board will notify the applicant in writing of examination results.

31.3(4) Persons determined by the board not to have performed satisfactorily may apply for reexamination.

31.3(5) The passing score on the written examination shall be the passing point criterion established by the appropriate national testing authority at the time the test was administered.

31.3(6) An applicant who is requesting approval to take the licensure examination prior to graduation shall:

a. Apply for licensure by creating an account and paying online at ibplicense.iowa.gov or by completing and returning a paper application with a check or money order payable to the Board of Behavioral Science.

b. Have a letter on official school letterhead sent directly from the program director to the board indicating that the applicant is in good academic standing; that the applicant will graduate from the program within three months of the date on the letter; and the applicant's anticipated date of graduation.

[ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19; ARC 5010C, IAB 3/25/20, effective 4/29/20]

645—31.4(154D) Educational qualifications for marital and family therapists. The applicant must complete the required semester credit hours, or equivalent quarter hours, of graduate level coursework in each of the content areas identified in 31.4(2); no course may be used more than once. The applicant must present proof of completion of the following educational requirements for licensure as a marital and family therapist:

31.4(1) Accredited program. Applicants must present with the application an official transcript verifying completion of a master's degree of 60 semester hours (or 80 quarter hours or equivalent) or a doctoral degree in marital and family therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) from a college or university accredited by an agency recognized by the United States Department of Education. Applicants who

entered a program of study prior to July 1, 2010, must present with the application an official transcript verifying completion of a master's degree of 45 semester hours or the equivalent; or

31.4(2) Content-equivalent program. Applicants must present an official transcript verifying completion of a master's degree of 60 semester hours (or 80 quarter hours or equivalent) or a doctoral degree in marital and family therapy, behavioral science, or a counseling-related field from a college or university accredited by an agency recognized by the United States Department of Education, which is content-equivalent to a graduate degree in marital and family therapy. Applicants who entered a program of study prior to July 1, 2010, must present with the application an official transcript verifying completion of a master's degree of 45 semester hours or the equivalent. Graduates from non-COAMFTE-accredited marital and family therapy programs shall provide an equivalency evaluation of the graduates' educational credentials by the Center for Credentialing and Education, Inc. (CCE), website cce-global.org. The professional curriculum must be equivalent to that stated in these rules. Applicants shall bear the expense of the curriculum evaluation. In order to qualify as a "content-equivalent" degree, a graduate transcript must document:

a. At least 9 semester hours or the equivalent in each of the three areas listed below:

(1) Theoretical foundations of marital and family therapy systems. Any course which deals primarily in areas such as family life cycle; theories of family development; marriage or the family; sociology of the family; families under stress; the contemporary family; family in a social context; the cross-cultural family; youth/adult/aging and the family; family subsystems; individual, interpersonal relationships (marital, parental, sibling).

(2) Assessment and treatment in family and marital therapy. Any course which deals primarily in areas such as family therapy methodology; family assessment; treatment and intervention methods; overview of major clinical theories of marital and family therapy, such as communications, contextual, experiential, object relations, strategic, structural, systemic, transgenerational.

(3) Human development. Any course which deals primarily in areas such as human development; personality theory; human sexuality. One course must be psychopathology.

b. At least 3 semester hours or the equivalent in each of the two areas listed below:

(1) Ethics and professional studies. Any course which deals primarily in areas such as professional socialization and the role of the professional organization; legal responsibilities and liabilities; independent practice and interprofessional cooperation; ethical issues in marital and family counseling; and family law.

(2) Research. Any course which deals primarily in areas such as research design, methods, statistics; research in marital and family studies and therapy.

If the applicant has taught a graduate-level course as outlined above at a college or university accredited by an agency recognized by the United States Department of Education or the Council on Professional Accreditation, that course will be credited toward the course requirements.

c. A graduate-level clinical practicum in marital and family therapy of at least 300 clock hours is required for all applicants.

[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 9547B, IAB 6/1/11, effective 7/6/11; ARC 2845C, IAB 12/7/16, effective 1/11/17]

645—31.5(154D) Clinical experience requirements for marital and family therapists.

31.5(1) The supervised clinical experience shall:

a. Be a minimum of two years of full-time, postgraduate supervised professional work experience in marital and family therapy.

b. Be completed following completion of the practicum, internship, and all graduate coursework, with the exception of the thesis.

c. Include successful completion of at least 3,000 hours of marital and family therapy that shall include at least 1,500 hours of direct client contact and 200 hours of clinical supervision. Applicants who entered a program of study prior to July 1, 2010, shall include successful completion of 200 hours of clinical supervision concurrent with 1,000 hours of marital and family therapy conducted in person with couples, families and individuals.

d. Include a minimum of 25 percent of all clinical supervision in person.

- (1) The first two meetings shall be face-to-face and in person.
- (2) Up to 50 percent of all supervision may be completed by telephone.
- (3) Up to 75 percent of all supervision may be completed by electronic means.
- (4) Supervision by electronic means is acceptable if the system utilized is a confidential, interactive, secure, real-time system that provides for visual and audio interaction between the licensee and the supervisor.

e. Include in the 200 hours of clinical supervision at least 100 hours of individual supervision.

f. Follow and maintain a plan throughout the supervisory period established by the supervisor and the licensee. Such a plan must be kept by the licensee for a period of five years following receipt of the permanent license and must be submitted to the board upon request. The plan for supervision shall include:

- (1) The name, license number, date of licensure, address, telephone number, and email address (when available) of the supervisor;
- (2) The name, license number, address, telephone number, and email address (when available) of supervisee;
- (3) Employment setting in which experience will occur;
- (4) The nature, duration and frequency of supervision;
- (5) The number of hours of supervision per month;
- (6) The supervisor/licensees type (individual/group) and mode (face-to-face/electronic) of supervision;
- (7) The methodology for secure transmission of case information;
- (8) The beginning date of supervised professional practice and estimated date of completion;
- (9) The goals and objectives for the supervised professional practice; and
- (10) The signatures of the supervisor and licensee, and the dates of signatures.

g. Have only supervised clinical contact credited for this requirement.

31.5(2) To meet the requirements of the supervised clinical experience:

a. The supervisee must:

- (1) Meet with the supervisor for a minimum of four hours per month;
- (2) Offer documentation of supervised hours signed by the supervisor;
- (3) Compute part-time employment on a prorated basis for the supervised professional experience;
- (4) Have the background, training, and experience that is appropriate to the functions performed;
- (5) Have supervision that is clearly distinguishable from personal psychotherapy and is contracted in order to serve professional/vocational goals;
- (6) Have individual supervision that shall be in person with no more than one supervisor to two supervisees;
- (7) Have group supervision that may be completed with up to ten supervisees and a supervisor; and
- (8) Not participate in the following activities which are deemed unacceptable for clinical supervision:

1. Peer supervision, i.e., supervision by a person of equivalent, but not superior, qualifications, status, and experience.

2. Supervision, by current or former family members, or any other person, in which the nature of the personal relationship prevents, or makes difficult, the establishment of a professional relationship.

3. Administrative supervision, e.g., clinical practice performed under administrative rather than clinical supervision of an institutional director or executive.

4. A primarily didactic process wherein techniques or procedures are taught in a group setting, classroom, workshop, or seminar.

5. Consultation, staff development, or orientation to a field or program, or role-playing of family interrelationships as a substitute for current clinical practice in an appropriate clinical situation.

b. The supervisor shall:

- (1) Be an Iowa-licensed marital and family therapist with a minimum of three years of clinical experience following licensure; or

(2) Be a supervisor or supervisor candidate approved by the American Association for Marriage and Family Therapy Commission on Supervision; or

(3) Be licensed under Iowa Code chapter 147 and have a minimum of three years of full-time professional work experience, including experience in marital and family therapy, as approved by the board; and

(4) Meet a minimum of four hours per month with the supervisee; and

(5) Provide training that is appropriate to the functions to be performed; and

(6) Ensure that therapeutic work is completed under the professional supervision of a supervisor; and

(7) Not supervise any marital and family therapy or permit the supervisee to engage in any therapy which the supervisor cannot perform competently.

c. Effective October 1, 2020, the supervisor shall:

(1) Be an Iowa-licensed marital and family therapist with a minimum of three years of clinical experience following licensure or shall be a supervisor or supervisor candidate approved by the American Association for Marriage and Family Therapy Commission on Supervision; or

(2) Be an Iowa-licensed mental health counselor in Iowa with at least three years of clinical experience following licensure or shall be approved by the National Board for Certified Counselors (NBCC) as a supervisor; and

(3) Have completed at least a six-hour continuing education course in counseling supervision or one master's level course in counseling supervision; and

(4) Meet a minimum of four hours per month with the supervisee; and

(5) Provide training that is appropriate to the functions to be performed; and

(6) Ensure that therapeutic work is completed under the professional supervision of a supervisor; and

(7) Not supervise any marital and family therapy or permit the supervisee to engage in any therapy that the supervisor cannot perform competently.

d. Exceptions to paragraph 31.5(2)“c” shall be made on an individual basis. Requests for alternative supervisors must be submitted in writing, and the board must approve the supervisor prior to commencement of the supervision.

31.5(3) An applicant who has obtained American Association for Marriage and Family Therapy (AAMFT) clinical membership is considered to have met the clinical experience requirements of rule 645—31.5(154D). The applicant shall request that proof of current clinical membership be sent directly from AAMFT to the board.

[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 8152B, IAB 9/23/09, effective 10/28/09; ARC 9547B, IAB 6/1/11, effective 7/6/11; ARC 0777C, IAB 6/12/13, effective 7/17/13; ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 5010C, IAB 3/25/20, effective 4/29/20]

645—31.6(154D) Educational qualifications for mental health counselors. The applicant must complete three semester credit hours, or equivalent quarter hours, of graduate level coursework in each of the content areas identified in 31.6(2); no course may be used to fulfill more than one content area. The applicant must present proof of completion of the following educational requirements for licensure as a mental health counselor:

31.6(1) Accredited program. Applicants must present with the application an official transcript verifying completion of a master's degree of 60 semester hours (or equivalent quarter hours) or a doctoral degree in counseling with emphasis in mental health counseling from a mental health counseling program accredited by the Council on Accreditation of Counseling and Related Educational Programs (CACREP) from a college or university accredited by an agency recognized by the United States Department of Education. Applicants who entered a program of study prior to July 1, 2012, must present with the application an official transcript verifying completion of a master's degree of 45 semester hours or the equivalent; or

31.6(2) Content-equivalent program. Applicants must present an official transcript verifying completion of a master's degree or a doctoral degree from a college or university accredited by an agency recognized by the United States Department of Education which is content-equivalent

to a master's degree in counseling with emphasis in mental health counseling. Graduates from non-CACREP accredited mental health counseling programs shall provide an equivalency evaluation of their educational credentials by the Center for Credentialing and Education, Inc. (CCE), website cce-global.org. The professional curriculum must be equivalent to that stated in these rules. Applicants shall bear the expense of the curriculum evaluation.

a. The degree of an applicant who entered a program of study prior to July 1, 2012, will be considered "content-equivalent" if the degree includes 45 semester hours (or equivalent quarter hours) and successful completion of graduate-level coursework in each of the areas in subparagraphs (1) to (12). If the applicant has taught a graduate-level course in any of the areas in subparagraphs (1) to (12) at a college or university accredited by an agency recognized by the United States Department of Education, that course may be credited toward the coursework requirement.

(1) Counseling theories. Studies that provide an understanding of counseling theories, utilize personal and environmental data in the mental health counseling process, and investigate procedures that are appropriate to various counseling theories and specific settings.

(2) Supervised counseling practicum. A graduate-level clinical supervised counseling practicum in a mental health setting in which students must complete supervised practicum experiences that total a minimum of 100 clock hours over a minimum ten-week academic term. The practicum provides for the development of counseling skills under supervision. The student's practicum includes all of the following:

1. At least 40 hours of direct service with actual clients that contributes to the development of counseling skills;

2. Weekly interaction with an average of 1 hour per week of individual or triadic supervision throughout the practicum by a program faculty member, a student supervisor, or a site supervisor who is working in biweekly consultation with a program faculty member in accordance with the supervision contract;

3. An average of 1½ hours per week of group supervision that is provided on a regular schedule throughout the practicum by a program faculty member or a student supervisor; and

4. Evaluation of the student's counseling performance throughout the practicum, including documentation of a formal evaluation after the student completes the practicum.

(3) Human growth and development. Studies that provide an understanding of the nature and needs of individuals at all developmental levels. Studies in this area include, but are not limited to, the following:

1. Theories of human development across the life span;

2. Major theories of personality development; and

3. Human behavior, including an understanding of developmental crises, disability, psychopathology, and cultural factors as they affect both normal and abnormal behavior.

(4) Social and cultural foundations. Studies that provide an understanding of issues and trends in a multicultural and diverse society. Studies in this area include, but are not limited to, the following:

1. Multicultural and pluralistic trends, including characteristics and concerns of diverse groups;

2. Attitudes and behavior based on factors such as age, race, religious preference, physical disability, sexual orientation, ethnicity and culture, gender, socioeconomic status, and intellectual ability; and

3. Individual and group interventions with diverse populations.

(5) Helping relationships. Studies that provide an understanding of counseling and consultation processes. Studies in this area include, but are not limited to, the following:

1. Helping skills and counseling and consultation theories, including coverage of relevant research and factors considered in applications;

2. Counselor or consultant characteristics and behaviors that influence helping processes, including gender and ethnicity differences, verbal and nonverbal behaviors and personal characteristics, orientations, and skills; and

3. Client or consultee characteristics and behaviors that influence helping processes, including gender and ethnicity differences, verbal and nonverbal behaviors and personal characteristics, traits, capabilities, life circumstances, and developmental levels.

(6) Groups. Studies that provide an understanding of group development, dynamics, counseling theories, and group counseling methods and skills. Studies in this area include, but are not limited to, the following:

1. Principles of group dynamics, including group process components, developmental stage theories, and group members' roles and behaviors;

2. Group leadership styles and approaches, including characteristics of various types of group leaders and leadership styles;

3. Theories of group counseling, including commonalities, distinguishing characteristics, and pertinent research and literature; and

4. Group counseling methods, including group counselor orientations and behaviors, ethical considerations, appropriate selection criteria and methods, and methods of evaluation of effectiveness.

(7) Career and lifestyle development. Studies that provide an understanding of career development and the interrelationships among work, family, and other life factors. Studies in this area include, but are not limited to, the following:

1. Career development theories and decision-making models;

2. Career, avocational, educational and labor market sources, print media, computer-assisted career guidance, and computer-based career information;

3. Career development program planning;

4. Interrelationships among work, family, and other life factors such as multicultural and gender issues, as related to career development;

5. Career and educational placement, follow-up and evaluation; and

6. Assessment instruments relevant to career planning and decision making.

(8) Diagnosis and assessment treatment procedures. Studies that provide an understanding of individual and group approaches to assessment and evaluation. Studies in this area include, but are not limited to, the following:

1. Theoretical and historical bases for assessment techniques and methods of interpretation of appraisal data and information;

2. Types of educational and psychological appraisal as appropriate to the helping process;

3. Validity, including evidence for establishing content, construct, and empirical validity;

4. Reliability, including methods of establishing stability and internal and equivalence reliability;

5. Major appraisal methods, including environmental assessment, performance assessment, individual and group test and inventory methods, behavioral observations, and computer-managed and computer-assisted methods;

6. Psychometric statistics, including types of test scores, measures of central tendency, indices of variability, standard errors and correlations; and

7. Gender, ethnicity, language, disability, and cultural factors related to the assessment and evaluation of individuals and groups.

(9) Research and program evaluation. Studies that provide an understanding of types of research methods, basic statistics, and ethical and legal considerations in research. Studies in this area include, but are not limited to, the following:

1. Basic types of research methods, including qualitative, quantitative-descriptive, and quantitative-descriptive-experimental designs;

2. Basic statistics, including both univariate and bivariate hypothesis testing;

3. Uses of computers for data management and analyses; and

4. Ethical and legal considerations in research.

(10) Professional orientation. Studies that provide an understanding of all aspects of professional functioning, including history, roles, organizational structures, ethics, standards, and credentialing. Studies in this area include, but are not limited to, the following:

1. History of the helping professions, including significant factors and events;

2. Professional roles and functions, including similarities with and differences from other types of professionals;

3. Professional organizations (primarily ACA or AMHCA, their divisions, and their branches), including membership benefits, activities, services to members, and current emphases;

4. Ethical standards of the ACA or AMHCA and the evolution of those standards, legal issues, and applications to various professional activities (e.g., appraisal and group work);

5. Professional preparation standards and their evolution and current applications; and

6. Professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues.

(11) Supervised counseling internship that provides an opportunity for the trainee to perform under supervision a variety of activities that a regularly employed staff member in a setting would be expected to perform. A regularly employed staff member is defined as a person occupying the professional role to which the trainee is aspiring. The internship follows a supervised practicum experience. A three-semester-hour internship includes the following:

1. A minimum of 120 hours of direct service with clientele appropriate to the program of study;

2. A minimum of 1 hour per week of individual supervision, throughout the internship, usually performed by the on-site supervisor; and

3. A minimum of 1½ hours per week of group supervision, throughout the internship, usually performed by a program faculty member supervisor.

(12) Psychopathology. Studies that provide an understanding of the description, classification and diagnosis of behavior disorders and dysfunction. Studies in this area include, but are not limited to, the following:

1. Study of cognitive, behavioral, physiological and interpersonal mechanisms for adapting to change and to stressors;

2. Role of genetic, physiological, cognitive, environmental and interpersonal factors and their interactions on development of the form, severity, course and persistence of the various types of disorders and dysfunction;

3. Research methods and findings pertinent to the description, classification, diagnosis, origin, and course of disorders and dysfunction;

4. Theoretical perspectives relevant to the origin, development, and course and outcome for the forms of behavior disorders and dysfunction; and

5. Methods of intervention or prevention used to minimize and modify maladaptive behaviors, disruptive and distressful cognition, or compromised interpersonal functioning associated with various forms of maladaptation.

b. The degree of an applicant who entered a program of study on or after July 1, 2012, will be considered “content-equivalent” if the degree includes 60 semester hours (or equivalent quarter hours) and successful completion of graduate-level coursework in each of the areas in subparagraphs (1) to (12). If the applicant has taught a graduate-level course in any of the areas in subparagraphs (1) to (12) at a college or university accredited by an agency recognized by the United States Department of Education, that course may be credited toward the coursework requirement.

(1) Professional orientation and ethical practice. Studies that provide an understanding of all of the following aspects of professional functioning:

1. History and philosophy of the counseling profession, including mental health counseling;

2. Professional roles, functions, and relationships of the mental health counselor with other human services providers, including strategies for interagency/interorganization collaboration and communication;

3. Counselors’ roles and responsibilities as members of an interdisciplinary emergency management response team during a local, regional, or national crisis, disaster or other trauma-causing event;

4. Self-care strategies appropriate to the counselor role;

5. Counseling supervision models, practices, and processes;

6. Professional organizations (primarily ACA or AMHCA, and their divisions, branches, and affiliates), including membership benefits, activities, services to members, and current emphases;

7. Professional credentialing, including certification, licensure, and accreditation practices and standards, and the effects of public policy on these issues;

8. The role and process of the professional mental health counselor advocating on behalf of the profession;

9. Advocacy processes needed to address institutional and social barriers that impede access, equity, and success for clients; and

10. Ethical standards of ACA or AMHCA and related entities, and applications of ethical and legal considerations in professional counseling.

(2) Social and cultural diversity. Studies that provide an understanding of the cultural context of relationships, issues, and trends in a multicultural and diverse society including all of the following:

1. Multicultural and pluralistic trends, including characteristics and concerns within and among diverse groups nationally and internationally;

2. Attitudes, beliefs, understandings, and acculturative experiences, including specific experiential learning activities designed to foster students' understanding of self and culturally diverse clients;

3. Theories of multicultural counseling, identity development, and social justice;

4. Individual, couple, family, group, and community strategies for working with and advocating for diverse populations, including multicultural competencies;

5. Counselors' roles in developing cultural self-awareness, promoting cultural social justice, advocacy, and conflict resolution and other culturally supported behaviors that promote optimal wellness and growth of the human spirit, mind or body; and

6. Counselors' roles in eliminating biases, prejudices, and processes of intentional and unintentional oppression and discrimination.

(3) Human growth and development. Studies that provide an understanding of the nature and needs of persons at all developmental levels and in multicultural contexts, including all of the following:

1. Theories of individual and family development and transitions across the life span;

2. Theories of learning and personality development including current understandings about neurobiological behavior;

3. Effects of crises, disasters, and other trauma-causing events on persons of all ages;

4. Theories and models of individual, cultural, couple, family, and community resilience;

5. A general framework for understanding exceptional abilities and strategies for differentiated interventions;

6. Human behavior, including an understanding of developmental crises, disability, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior;

7. Theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention, and treatment; and

8. Strategies for facilitating optimum development over the life span.

(4) Career development. Studies that provide an understanding of career development and related life factors, including all of the following:

1. Career development theories and decision-making models;

2. Career, avocational, educational, occupational and labor market information resources and career information systems;

3. Career development program planning, organization, implementation, administration, and evaluation;

4. Interrelationships among and between work, family, and other life roles and factors including the role of multicultural issues in career development;

5. Career and educational planning, placement, follow-up, and evaluation;

6. Assessment instruments and techniques relevant to career planning and decision making; and

7. Career counseling processes, techniques, and resources, including those applicable to specific populations.

(5) Helping relationships. Studies that provide an understanding of counseling processes in a multicultural society, including all of the following:

1. An orientation to wellness and prevention as desired counseling goals;
2. Counselor characteristics and behaviors that influence helping processes;
3. An understanding of essential interviewing and counseling skills;
4. Counseling theories that provide the student with a model(s) to conceptualize client presentation and select appropriate counseling interventions. Students shall be exposed to models of counseling that are consistent with current professional research and practice in the field so that they can begin to develop a personal model of counseling;

5. A systems perspective that provides an understanding of family and other systems theories and major models of family and related interventions;

6. A general framework for understanding and practicing consultation; and

7. Crisis intervention and suicide prevention models, including the use of psychological first-aid strategies.

(6) Group work. Studies that provide both theoretical and experiential understanding of group purpose, development, dynamics, theories, methods, skills, and other group approaches in a multicultural society, including all of the following:

1. Principles of group dynamics, including group process components, developmental stage theories, group members' roles and behaviors, and therapeutic factors of group work;

2. Group leadership or facilitation styles and approaches, including characteristics of various types of group leaders and leadership styles;

3. Theories of group counseling, including commonalities, distinguishing characteristics, and pertinent research and literature;

4. Group counseling methods, including group counselor orientations and behaviors, appropriate selection criteria and methods, and methods of evaluation of effectiveness; and

5. Experiences in which students participate as group members in a small group activity, approved by the program, for a minimum of 10 clock hours over the course of one academic term.

(7) Assessment. Studies that provide an understanding of individual and group approaches to assessment and evaluation in a multicultural society, including the following:

1. Historical perspectives concerning the nature and meaning of assessment;

2. Basic concepts of standardized and nonstandardized testing and other assessment techniques including norm-referenced and criterion-referenced assessment, environmental assessment, performance assessment, individual and group test and inventory methods, and behavioral observations;

3. Statistical concepts, including scales of measurement, measures of central tendency, indices of variability, shapes and types of distributions, and correlations;

4. Reliability (i.e., theory of measurement error, models of reliability, and the use of reliability information);

5. Validity (i.e., evidence of validity, types of validity, and the relationship between reliability and validity);

6. Social and cultural factors related to the assessment and evaluation of individuals, groups, and specific populations;

7. Ethical strategies for selecting, administering, and interpreting assessment and evaluation instruments and techniques in counseling; and

8. An understanding of general principles and methods of case conceptualization, assessment, or diagnoses of mental and emotional status.

(8) Research and program evaluation. Studies that provide an understanding of research methods, statistical analysis, needs assessment, and program evaluation, including all of the following:

1. The importance of research in advancing the counseling profession;

2. Research methods such as qualitative, quantitative, single-case designs, action research, and outcome-based research;

3. Statistical methods used in conducting research and program evaluation;
4. Principles, models, and applications of needs assessment, program evaluation, and use of findings to effect program modifications;
5. Use of research to inform evidence-based practice; and
6. Ethical and culturally relevant strategies for interpreting and reporting the results of research and program evaluation studies.

(9) Diagnosis and treatment planning. Studies that provide an understanding of individual and group approaches to assessment and evaluation in a multicultural society. Studies in this area include, but are not limited to, the following:

1. The principles of the diagnostic process, including differential diagnosis, and the use of current diagnostic tools, such as the current edition of the Diagnostic and Statistical Manual;
2. The established diagnostic criteria for mental or emotional disorders that describe treatment modalities and placement criteria within the continuum of care;
3. The impact of co-occurring substance use disorders on medical and psychological disorders;
4. The relevance and potential biases of commonly used diagnostic tools as related to multicultural populations;
5. The appropriate use of diagnostic tools, including the current edition of the Diagnostic and Statistical Manual, to describe the symptoms and clinical presentation of clients with mental or emotional impairments;
6. The ability to conceptualize accurate multi-axial diagnoses of disorders presented by clients and discuss the differential diagnosis with collaborating professionals; and
7. The ability to differentiate between diagnosis and developmentally appropriate reactions during crises, disasters, and other trauma-causing events.

(10) Psychopathology. Studies that provide an understanding of emotional and mental disorders experienced by persons of all ages, characteristics of disorders, and common nosologies of emotional and mental disorders utilized within the U.S. health care system for diagnosis and treatment planning. Studies in this area include, but are not limited to, the following:

1. Study of cognitive, behavioral, physiological and interpersonal mechanisms for adapting to change and to stressors;
2. Role of genetic, physiological, cognitive, environmental and interpersonal factors and their interactions on development of the form, severity, course and persistence of the various types of disorders and dysfunction;
3. Research methods and findings pertinent to the description, classification, diagnosis, origin, and course of disorders and dysfunction;
4. Theoretical perspectives relevant to the origin, development, and course and outcome for the forms of behavior disorders and dysfunction; and
5. Methods of intervention or prevention used to minimize and modify maladaptive behaviors, disruptive and distressful cognition, or compromised interpersonal functioning associated with various forms of maladaptation.

(11) Practicum. A graduate-level clinical supervised counseling practicum in a mental health setting in which students must complete supervised practicum experiences that total a minimum of 100 clock hours over a minimum ten-week academic term. The practicum provides for the development of counseling skills under supervision. The student's practicum includes all of the following:

1. At least 40 hours of direct service with actual clients that contributes to the development of counseling skills;
2. Weekly interaction with an average of 1 hour per week of individual or triadic supervision throughout the practicum by a program faculty member, a student supervisor, or a site supervisor who is working in biweekly consultation with a program faculty member in accordance with the supervision contract;
3. An average of 1½ hours per week of group supervision that is provided on a regular schedule throughout the practicum by a program faculty member or a student supervisor; and

4. Evaluation of the student's counseling performance throughout the practicum including documentation of a formal evaluation after the student completes the practicum.

(12) Internship. A graduate-level clinical supervised counseling internship in a mental health setting that requires students to complete a supervised internship of 600 clock hours that is begun after the student's successful completion of the practicum. The internship is intended to reflect the comprehensive work experience of a professional counselor appropriate to clinical mental health counseling. The internship provides an opportunity for the student to perform, under supervision, a variety of counseling activities that a mental health counselor is expected to perform. The student's internship includes all of the following:

1. At least 240 hours of direct service with clientele, including experience leading groups;
2. Weekly interaction that averages 1 hour per week of individual supervision or triadic supervision throughout the internship, usually performed by the on-site supervisor;
3. An average of 1½ hours per week of group supervision, provided on a regular schedule throughout the internship, usually performed by a program faculty member supervisor;
4. The opportunity for the student to become familiar with a variety of professional activities in addition to direct service (e.g., record keeping, supervision, information and referral, in-service and staff meetings);
5. The opportunity for the student to develop program-appropriate audio/video recordings for use in supervision or to receive live supervision of the student's interactions with clients;
6. The opportunity for the student to gain supervised experience in the use of a variety of professional resources such as assessment instruments, technologies, print and nonprint media, professional literature, and research; and
7. Evaluation of the student's counseling performance throughout the internship including documentation of a formal evaluation by a program faculty member in consultation with the site supervisor after the student completes the internship.

31.6(3) *Foreign-trained marital and family therapists or mental health counselors.* Foreign-trained marital and family therapists or mental health counselors shall:

- a. Provide an equivalency evaluation of their educational credentials by the following: International Educational Research Foundations, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, CA 90231-3665; telephone (310)258-9451; website www.ierf.org or email at info@ierf.org. The professional curriculum must be equivalent to that stated in these rules. A candidate shall bear the expense of the curriculum evaluation.
- b. Provide a notarized copy of the certificate or diploma awarded to the applicant from a mental health counselor program in the country in which the applicant was educated.
- c. Receive a final determination from the board regarding the application for licensure.

[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 9547B, IAB 6/1/11, effective 7/6/11; ARC 1758C, IAB 12/10/14, effective 1/14/15; ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 5010C, IAB 3/25/20, effective 4/29/20]

645—31.7(154D) Clinical experience requirements for mental health counselors.

31.7(1) The supervised clinical experience shall:

- a. Be a minimum of two years of postgraduate supervised professional work experience in mental health counseling.
- b. Be completed following completion of the practicum, internship, and all graduate coursework, with the exception of the thesis.
- c. Include successful completion of at least 3,000 hours of mental health counseling that shall include at least 1,500 hours of direct client contact and 200 hours of clinical supervision. Applicants who entered a program of study prior to July 1, 2010, shall include successful completion of 200 hours of clinical supervision concurrent with 1,000 hours of mental health counseling conducted in person with couples, families and individuals.
- d. Include a minimum of 25 percent of all clinical supervision in person.
 - (1) The first two meetings shall be face-to-face and in person.
 - (2) Up to 50 percent of all supervision may be completed by telephone.

- (3) Up to 75 percent of all supervision may be completed by electronic means.
 - (4) Supervision by electronic means is acceptable if the system utilized is a confidential, interactive, secure, real-time system that provides for visual and audio interaction between the licensee and the supervisor.
 - e. Include in the 200 hours of clinical supervision at least 100 hours of individual supervision.
 - f. Follow and maintain a plan throughout the supervisory period established by the supervisor and the licensee. Such a plan must be kept by the licensee for a period of five years following receipt of the permanent license and must be submitted to the board upon request. The plan for supervision shall include:
 - (1) The name, license number, date of licensure, address, telephone number, and email address (when available) of the supervisor;
 - (2) The name, license number, address, telephone number, and email address (when available) of supervisee;
 - (3) Employment setting in which experience will occur;
 - (4) The nature, duration and frequency of supervision;
 - (5) The number of hours of supervision per month;
 - (6) The supervisor/licensees type (individual/group) and mode (face-to-face/electronic) of supervision;
 - (7) The methodology for secure transmission of case information;
 - (8) The beginning date of supervised professional practice and estimated date of completion;
 - (9) The goals and objectives for the supervised professional practice; and
 - (10) The signatures of the supervisor and licensee, and the dates of signatures.
 - g. Have only supervised clinical contact credited for this requirement.
- 31.7(2)** To meet the requirements of the supervised clinical experience:
- a. The supervisee must:
 - (1) Meet with the supervisor a minimum of four hours per month;
 - (2) Offer documentation of supervised hours signed by the supervisor;
 - (3) Compute part-time employment on a prorated basis for the supervised professional experience;
 - (4) Have the background, training, and experience that are appropriate to the functions performed;
 - (5) Have supervision that is clearly distinguishable from personal counseling and is contracted in order to serve professional/vocational goals;
 - (6) Have individual supervision that shall be in person with no more than one supervisor to two supervisees;
 - (7) Have group supervision that may be completed with up to ten supervisees and a supervisor; and
 - (8) Not participate in the following activities which are deemed unacceptable for clinical supervision:
 1. Peer supervision, i.e., supervision by a person of equivalent, but not superior, qualifications, status, and experience.
 2. Supervision, by current or former family members, or any other person, in which the nature of the personal relationship prevents, or makes difficult, the establishment of a professional relationship.
 3. Administrative supervision, e.g., clinical practice performed under administrative rather than clinical supervision of an institutional director or executive.
 4. A primarily didactic process wherein techniques or procedures are taught in a group setting, classroom, workshop, or seminar.
 5. Consultation, staff development, or orientation to a field or program, or role-playing of family interrelationships as a substitute for current clinical practice in an appropriate clinical situation.
 - b. The supervisor:
 - (1) May be a licensed mental health counselor in Iowa with at least three years of postlicensure clinical experience; or
 - (2) Shall be approved by the National Board for Certified Counselors (NBCC) as a supervisor; or

(3) May be an alternate supervisor who possesses qualifications equivalent to a licensed mental health counselor with at least three years of postlicensure clinical experience, including mental health professionals licensed to practice independently; and

(4) Shall meet a minimum of four hours per month with the supervisee; and

(5) Shall provide training that is appropriate to the functions to be performed; and

(6) Shall ensure that therapeutic work is done under the professional supervision of a supervisor; and

(7) Shall not supervise any mental health counselor or permit the supervisee to engage in any therapy which the supervisor cannot perform competently.

c. Effective October 1, 2020, the supervisor shall:

(1) Be an Iowa-licensed mental health counselor in Iowa with at least three years of clinical experience following licensure or shall be approved by the National Board for Certified Counselors (NBCC) as a supervisor; or

(2) Be an Iowa-licensed marital and family therapist with a minimum of three years of clinical experience following licensure or shall be a supervisor or supervisor candidate approved by the American Association for Marriage and Family Therapy Commission on Supervision; and

(3) Have completed at least a six-hour continuing education course in counseling supervision or one master's level course in counseling supervision; and

(4) Meet a minimum of four hours per month with the supervisee; and

(5) Provide training that is appropriate to the functions to be performed; and

(6) Ensure that therapeutic work is completed under the professional supervision of a supervisor; and

(7) Not supervise any mental health counselor or permit the supervisee to engage in any therapy that the supervisor cannot perform competently.

d. Exceptions to paragraph 31.7(2)“c” shall be made on an individual basis. Requests for alternative supervisors must be submitted in writing, and the board must approve the supervisor prior to commencement of the supervision.

31.7(3) Rescinded IAB 7/6/05, effective 8/10/05.

31.7(4) An applicant who has obtained Certified Clinical Mental Health Counselor status with the National Board for Certified Counselors (NBCC) is considered to have met the clinical experience requirements of rule 645—31.7(154D). The applicant shall ensure that proof of current certified clinical mental health counselor status be sent directly from NBCC to the board.

[**ARC 7673B**, IAB 4/8/09, effective 4/30/09; **ARC 8152B**, IAB 9/23/09, effective 10/28/09; **ARC 9547B**, IAB 6/1/11, effective 7/6/11; **ARC 0777C**, IAB 6/12/13, effective 7/17/13; **ARC 2845C**, IAB 12/7/16, effective 1/11/17; **ARC 5010C**, IAB 3/25/20, effective 4/29/20]

645—31.8(154D) Licensure by endorsement for mental health counselors and marital and family therapists. An applicant who has been a licensed marriage and family therapist or mental health counselor under the laws of another jurisdiction may file an application for licensure by endorsement with the board office.

31.8(1) The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:

a. Submits to the board a completed application;

b. Pays the licensure fee;

c. Shows evidence of licensure requirements that are similar to those required in Iowa;

d. Provides official transcripts sent directly from the school to the board verifying completion of a master's degree of 45 hours or equivalent if the applicant entered a program of study prior to July 1, 2012, or verifying completion of a master's degree of 60 hours or equivalent if the applicant entered a program of study on or after July 1, 2012, or the appropriate doctoral degree. Graduates from a non-CACREP-accredited mental health counselor program or a non-COAMFTE-accredited marital and family therapy program shall provide an equivalency evaluation of their educational credentials by the Center for Credentialing and Education, Inc. (CCE), website cce-global.org. The professional

curriculum must be equivalent to that stated in these rules. Applicants shall bear the expense of the curriculum evaluation;

e. Supplies satisfactory evidence of the candidate's qualifications in writing on the prescribed forms by the candidate's supervisors. If verification of clinical experience is not available, the board may consider submission of documentation from the state in which the applicant is currently licensed or equivalent documentation of supervision;

f. Provides verification(s) 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:

- (1) Licensee's name;
- (2) Date of initial licensure;
- (3) Current licensure status; and
- (4) Any disciplinary action taken against the license; and

g. Has the examination score sent directly from the testing service to the board.

31.8(2) In lieu of meeting the requirements of paragraphs 31.8(1) "d" and "e," applicants who meet the qualifications below may instead submit documentation demonstrating how each of the qualifications below is satisfied:

a. The applicant has been licensed as a mental health counselor or a marital and family therapist in another state for at least five years at the independent level (independent level means the highest level of licensure in the field offered by the particular state);

b. The applicant has been practicing under the independent license in a clinical mental health or marital and family therapy counseling setting for at least five years;

c. The applicant possesses a master's degree or higher in mental health counseling or marital and family therapy or an equivalent counseling-related field; and

d. The applicant does not have any past or pending disciplinary action from any state licensing boards related to any mental health counseling or marital and family therapy license currently or previously held by the applicant.

[ARC 7673B, IAB 4/8/09, effective 4/30/09; ARC 0777C, IAB 6/12/13, effective 7/17/13; ARC 1758C, IAB 12/10/14, effective 1/14/15; ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19]

645—31.9(147) Licensure of behavior analysts and assistant behavior analysts.

31.9(1) The applicant shall complete a board-approved application. Application forms may be obtained from the board's website (www.idph.iowa.gov/licensure) or directly from the board office. All paper applications shall be sent to the Board of Behavioral Science, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

31.9(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.

31.9(3) Each application shall be accompanied by the appropriate fees payable to the board of behavioral science. The fees are nonrefundable.

31.9(4) For licensure as a behavior analyst, the applicant shall submit proof of current BACB certification as a board-certified behavior analyst or board-certified behavior analyst-doctoral. For licensure as an assistant behavior analyst, the applicant shall submit proof of current BACB certification as a board-certified assistant behavior analyst.

[ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19]

645—31.10(147) License renewal for mental health counselors and marriage and family therapists.

31.10(1) The biennial license renewal period for a license to practice marital and family therapy or mental health counseling shall begin on October 1 of an even-numbered year and end on September 30 of the next even-numbered year. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

31.10(2) An individual who was issued an initial license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

31.10(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—32.2(272C). 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.

c. 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.

31.10(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting as required by Iowa Code section 232.69(3) "b" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph "d."

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 as required by Iowa Code section 235B.16(5) "b" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph "d."

c. The licensee shall maintain written documentation for five years after mandatory training as identified in paragraphs "a" and "b," including program date(s), content, duration, and proof of participation.

d. 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 4.

e. The board may select licensees for audit of compliance with the requirements in paragraphs "a" to "d."

31.10(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.

31.10(6) A person licensed to practice as a marital and family therapist or mental health counselor shall keep the person's license certificate and wallet card displayed in a conspicuous public place at the primary site of practice.

31.10(7) 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 5.3(3). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

31.10(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice mental health counseling or marital and family therapy in Iowa until the license is reactivated. A licensee who practices mental health counseling or marital and family therapy 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 9547B, IAB 6/1/11, effective 7/6/11; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19; ARC 5010C, IAB 3/25/20, effective 4/29/20]

645—31.11(272C) Initial licensing, reactivation, and license renewal for behavior analysts and assistant behavior analysts.

31.11(1) An initial license for a behavior analyst or assistant behavior analyst shall be issued with the same expiration date as the applicant's current certification issued by BACB.

31.11(2) The biennial license renewal period for a behavior analyst or assistant behavior analyst shall run concurrent with the licensee's BACB certification. Each license renewed shall be given the expiration date that is on the licensee's current BACB certification. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

31.11(3) A licensee seeking renewal shall:

- a. Meet the continuing education requirements required by BACB to renew a certification.
- b. Maintain current certification as a board-certified behavior analyst, board-certified behavior analyst-doctoral, or board-certified assistant behavior analyst issued by BACB.
- c. Submit the completed renewal application and renewal fee before the license expiration date.

31.11(4) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a license. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

31.11(5) A person licensed as a behavior analyst or assistant behavior analyst shall keep the person's license certificate and wallet card displayed in a conspicuous public place at the primary site of practice.

31.11(6) 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 5.3(5). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

31.11(7) 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 engage in the practice of applied behavior analysis for which a license is required in Iowa until the license is reactivated. A licensee who practices applied behavior analysis in a capacity that requires licensure 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.

31.11(8) Reactivation. To apply for reactivation of an inactive license, a licensee shall submit a completed renewal application and proof of current certification and shall be assessed a reactivation fee as specified in 645—subrule 5.3(6).

[ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19]

645—31.12(147) Licensee record keeping.

31.12(1) A licensee shall maintain sufficient, timely, and accurate documentation in client records.

31.12(2) For purposes of this rule, "client" means the individual, couple, family, or group to whom a licensee provides direct clinical services.

31.12(3) A licensee's records shall reflect the services provided, facilitate the delivery of services, and ensure continuity of services in the future.

31.12(4) Clinical services. A licensee who provides clinical services in any employment setting, including private practice, shall:

a. Store records in accordance with state and federal statutes and regulations governing record retention and with the guidelines of the licensee's employer or agency, if applicable. If no other legal provisions govern record retention, a licensee shall store all client records for a minimum of seven years after the date of the client's discharge or death, or, in the case of a minor, for three years after the client reaches the age of majority under state law or seven years after the date of the client's discharge or death, whichever is longer.

b. Maintain timely records that include subjective and objective data, an assessment, a treatment plan, and any revisions to the assessment or plan made during the course of treatment.

c. Provide the client with reasonable access to records concerning the client. A licensee who is concerned that a client's access to the client's records could cause serious misunderstanding or harm to the client shall provide assistance in interpreting the records and consultation with the client regarding the records. A licensee may limit a client's access to the client's records, or portions of the records, only in exceptional circumstances when there is compelling evidence that such access would cause serious harm to the client. Both the client's request for access and the licensee's rationale for withholding some or all of a record shall be documented in the client's records.

d. Take steps to protect the confidentiality of other individuals identified or discussed in any records to which a client is provided access.

31.12(5) Electronic record keeping. The requirements of this rule apply to electronic records as well as to records kept by any other means. When electronic records are kept, the licensee shall ensure that a duplicate hard-copy record or a backup, unalterable electronic record is maintained.

31.12(6) Correction of records.

a. *Hard-copy records.* Original notations shall be legible, written in ink, and contain no erasures or whiteouts. If incorrect information is placed in the original record, it must be crossed out with a single, nondeleting line and be initialed and dated by the licensee.

b. *Electronic records.* If a record is stored in an electronic format, the record may be amended with a signed addendum attached to the record.

31.12(7) Confidentiality and transfer of records. Marital and family therapists or mental health counselors shall preserve the confidentiality of client records in accordance with their respective rules of conduct and with federal and state law. Upon receipt of a written release or authorization signed by the client, the licensee shall furnish such therapy records, or copies of the records, as will be beneficial for the future treatment of that client. A fee may be charged for duplication of records, but a licensee may not refuse to transfer records for nonpayment of any fees. A written request may be required before transferring the record(s).

31.12(8) Retirement, death or discontinuance of practice.

a. If a licensee is retiring or discontinuing practice and is the owner of a practice, the licensee shall notify in writing all active clients and, upon knowledge and agreement of the clients, shall make reasonable arrangements with those clients to transfer client records, or copies of those records, to the succeeding licensee.

b. Upon a licensee's death:

(1) The licensee's employer or representative must ensure that all client records are transferred to another licensee or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The licensee's employer or representative shall notify each active client that the client's records will be transferred to another licensee or entity that will retain custody of the records and that, at the client's written request, the records will be sent to the licensee or entity of the client's choice.

31.12(9) Nothing stated in this rule shall prohibit a licensee from conveying or transferring the licensee's client records to another licensed individual who is assuming a practice, provided that written notice is furnished to all clients.

645—31.13(147) Duplicate certificate or wallet card. Rescinded IAB 1/14/09, effective 2/18/09.

645—31.14(147) Reissued certificate or wallet card. Rescinded IAB 1/14/09, effective 2/18/09.

645—31.15(17A,147,272C) License denial. Rescinded IAB 1/14/09, effective 2/18/09.

645—31.16(17A,147,272C) License reactivation for mental health counselors and marital and family therapists. To apply for reactivation of an inactive license, a licensee shall:

31.16(1) Submit a reactivation application on a form provided by the board.

31.16(2) Pay the reactivation fee that is due as specified in 645—Chapter 5.

31.16(3) Provide verification of current competence to practice mental health counseling or marital and family therapy 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 40 hours of continuing education obtained within the two years immediately preceding the 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 80 hours of continuing education obtained within the two years immediately preceding the application for reactivation.

[ARC 0777C, IAB 6/12/13, effective 7/17/13; ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19]

645—31.17(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—31.16(17A,147,272C) or subrule 31.11(8) prior to practicing mental health counseling, marital and family therapy, or applied behavior analysis in this state.

[ARC 4390C, IAB 4/10/19, effective 3/22/19; ARC 4557C, IAB 7/17/19, effective 8/21/19]

645—31.18(154D) Marital and family therapy and mental health counselor services subject to regulation. Marital and family therapy and mental health counselor services provided to an individual in this state through telephonic, electronic or other means, regardless of the location of the marital and family therapy and mental health counselor, shall constitute the practice of marital and family therapy and mental health counseling and shall be subject to regulation in Iowa.

645—31.19(154D) Temporary licensees. A temporary licensee shall engage only in the practice of marital and family therapy or mental health counseling as part of an agency or group practice with oversight over the temporary licensee. The agency or group practice shall have at least one independently licensed mental health provider. A temporary licensee shall not practice as a solo practitioner or solely with other temporary licensees.

[ARC 5010C, IAB 3/25/20, effective 4/29/20]

These rules are intended to implement Iowa Code chapters 17A, 147, 154D and 272C.

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 [Filed Emergency ARC 4390C, IAB 4/10/19, effective 3/22/19]
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 [Filed ARC 5010C (Notice ARC 4745C, IAB 11/6/19), IAB 3/25/20, effective 4/29/20]

[◇] Two or more ARCs

¹ February 18, 2009, effective date of amendments to 645—31.4(154D) to 645—31.8(154D), **ARC 7476B**, Items 5 to 9, delayed 70 days by the Administrative Rules Review Committee at its meeting held February 6, 2009.

CHAPTER 32
CONTINUING EDUCATION FOR MARITAL AND
FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS

645—32.1(272C) Definitions. For the purpose of these rules, the following definitions shall apply:

“*Active license*” means the license 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 behavioral science.

“*Continuing education*” means planned, organized learning acts designed to maintain, improve, or expand a licensee’s knowledge and skills in order for the licensee to develop new knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

“*Hour of continuing education*” means at least 50 minutes spent by a licensee in actual attendance at and completion of 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 continuing education program or activity that a licensee pursues autonomously that includes a posttest and meets the general criteria in subrule 32.3(1).

“*License*” means license to practice.

“*Licensee*” means any person licensed to practice marital and family therapy or mental health counseling in the state of Iowa.

[ARC 5011C, IAB 3/25/20, effective 4/29/20]

645—32.2(272C) Continuing education requirements.

32.2(1) The biennial continuing education compliance period shall extend for a 25-month period beginning on September 1 of the even-numbered year and ending on September 30 of the next even-numbered year. Each biennium, each person who is licensed to practice as a licensee in this state shall be required to complete a minimum of 40 hours of continuing education approved by the board.

32.2(2) Requirements of new licensees. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The new licensee will be required to complete a minimum of 40 hours of continuing education per biennium for each subsequent license renewal.

32.2(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.

32.2(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.

32.2(5) It is the responsibility of each licensee to finance the cost of continuing education.

[ARC 5011C, IAB 3/25/20, effective 4/29/20]

645—32.3(154D,272C) Standards.

32.3(1) General criteria. A continuing education activity which meets all of the following criteria is appropriate for continuing education credit if the continuing education activity:

a. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee;

b. Pertains to subject matters which integrally relate to the practice of the profession;

c. Is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program. At the time of audit, the board may request the qualifications of presenters.

d. Fulfills stated program goals, objectives, or both; and

e. Provides proof of attendance to licensees in attendance including:

(1) Date(s), location, course title, presenter(s);

(2) Number of program contact hours; and

(3) Certificate of completion or evidence of successful completion of the course provided by the course sponsor.

32.3(2) *Specific criteria.* Continuing education hours of credit may be obtained by completing the following:

a. Attendance at workshops, conferences, symposiums and webinars.

b. Academic courses. Official transcripts indicating successful completion of academic courses which apply to the field of mental health counseling or marital and family therapy, as appropriate, will be necessary in order to receive the following continuing education credits:

1 academic semester hour = 15 continuing education hours

1 academic quarter hour = 10 continuing education hours

c. Completion of independent study courses that meet the general criteria in subrule 32.3(1).

d. A maximum of 20 hours of continuing education credit may be granted for any of the following activities not to exceed a combined total of 20 hours:

(1) Presenting professional programs which meet the criteria in 645—32.3(272C). Two hours of credit will be awarded for each hour of presentation. A course schedule or brochure must be maintained for audit. Presentation at a professional program does not include teaching class at an institution of higher learning at which the applicant is regularly and primarily employed. Presentations to lay public are excluded.

(2) Scholarly research or other activities, the results of which are published in a recognized professional publication such as a refereed journal, monograph or conference proceedings. The scholarly research must be integrally related to the practice of the professions.

(3) Publication in a refereed journal. The article in a refereed journal for which the licensee is seeking continuing education credit must be integrally related to the practice of the professions.

(4) Teaching in an approved college, university, or graduate school. The licensee may receive credit on a one-time basis for the first offering of the course.

(5) Authoring papers, publications, and books. The licensee shall receive five hours of credit per page with a maximum of 20 hours of credit.

(6) Serving on a state or national professional board. The licensee shall receive a maximum of three hours of credit.

32.3(3) *Required specific criteria:*

a. Three hours of the 40 continuing education hours shall be in ethics.

b. Effective with the biennial continuing education compliance period that begins October 1, 2022, persons serving in a supervisory role must complete three hours of continuing education in supervision.

c. Effective July 1, 2019, a licensee who regularly examines, attends, counsels or treats adults in Iowa shall complete, within six months of employment or prior to the expiration of a current certification, an initial two-hour course in dependent adult abuse training for mandatory reporters offered by the department of human services. Thereafter, all mandatory reporters shall take a one-hour recertification training every three years, prior to the expiration of a current certification.

d. Effective July 1, 2019, a licensee who regularly examines, attends, counsels or treats children in Iowa shall complete, within six months of employment or prior to the expiration of a current certification, an initial two-hour course in child abuse training for mandatory reporters offered by the department of human services. Thereafter, all mandatory reporters shall take a one-hour recertification training every three years, prior to the expiration of a current certification.

[ARC 2845C, IAB 12/7/16, effective 1/11/17; ARC 5011C, IAB 3/25/20, effective 4/29/20]

645—32.4(154D,272C) Audit of continuing education report. Rescinded IAB 6/1/11, effective 7/6/11.

645—32.5(154D,272C) Automatic exemption. Rescinded IAB 1/14/09, effective 2/18/09.

645—32.6(154D,272C) Grounds for disciplinary action. Rescinded IAB 1/14/09, effective 2/18/09.

645—32.7(272C) Continuing education waiver for active practitioners. Rescinded IAB 7/6/05, effective 8/10/05.

645—32.8(272C) Continuing education exemption for inactive practitioners. Rescinded IAB 7/6/05, effective 8/10/05.

645—32.9(154D,272C) Continuing education exemption for disability or illness. Rescinded IAB 1/14/09, effective 2/18/09.

645—32.10(272C) Reinstatement of inactive practitioners. Rescinded IAB 7/6/05, effective 8/10/05.

645—32.11(272C) Hearings. Rescinded IAB 7/6/05, effective 8/10/05.

These rules are intended to implement Iowa Code section 272C.2 and chapter 154D.

[Filed 2/1/01, Notice 10/18/00—published 2/21/01, effective 3/28/01]

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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.

“*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 and a pharmacy technician trainee.

“*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 a licensed pharmacy in Iowa and who is responsible for the actions of a pharmacy technician or other supportive personnel. [ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9009B, IAB 8/11/10, effective 7/23/10; ARC 1785C, IAB 12/10/14, effective 1/14/15]

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 or pharmacy technician trainee 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; ARC 1785C, IAB 12/10/14, effective 1/14/15]

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 or pharmacy technician trainee pursuant to these rules. An individual accepting employment as a pharmacy technician in Iowa who fails to register as a certified pharmacy technician or pharmacy technician trainee 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 or pharmacy technician trainee 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; ARC 1785C, IAB 12/10/14, effective 1/14/15]

657—3.4 Reserved.

657—3.5(155A) Certification of pharmacy technicians. Except as provided in subrule 3.5(1), all pharmacy technicians shall be required to be nationally certified as provided by this rule. National certification acquired through successful completion of any NCCA-accredited pharmacy technician certification program and examination fulfills the requirement for national certification. 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) Pharmacy technician trainee. 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(2) Certified pharmacy technician. All applicants for a new pharmacy technician registration except as provided by subrule 3.5(1), and all applicants for renewal of a pharmacy technician registration, 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; ARC 1785C, IAB 12/10/14, effective 1/14/15]

657—3.6(155A) Extension of deadline for national certification. Rescinded ARC 1785C, IAB 12/10/14, effective 1/14/15.

657—3.7 Reserved.

657—3.8(155A) Application form.

3.8(1) Required information. The application for a certified pharmacy technician registration or pharmacy technician trainee 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. Pharmacy technician trainee. The applicant for pharmacy technician trainee registration shall identify the source of pharmacy technician training, the anticipated date of completion of training, and the anticipated date of national certification.

b. Certified pharmacy technician. The applicant for certified pharmacy technician registration shall provide proof of current national 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" or "b" 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.

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; ARC 1785C, IAB 12/10/14, effective 1/14/15]

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. 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 pharmacy technician trainee completes national certification, and no later than the date of expiration of the pharmacy 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 pharmacy technician trainee who fails to complete national certification prior to expiration of the pharmacy 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 pharmacy technician trainee registration regarding the individual's intentions as provided in paragraph "a" or "b," the pharmacy technician trainee registration shall be canceled and the individual shall cease practice as a pharmacy technician.

[ARC 9009B, IAB 8/11/10, effective 7/23/10; ARC 1785C, IAB 12/10/14, effective 1/14/15]

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 pharmacy technician registration. The fee for obtaining an initial certified pharmacy technician registration or for biennial renewal of a certified pharmacy technician registration shall be \$40 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; ARC 0504C, IAB 12/12/12, effective 1/16/13; ARC 1785C, IAB 12/10/14, effective 1/14/15]

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).

c. A late payment fee shall not be assessed on an expired registration if the person was not employed as a pharmacy technician during the period following expiration of the registration.

[ARC 0504C, IAB 12/12/12, effective 1/16/13]

657—3.12(155A) Registration certificates. The certificate of pharmacy technician registration issued by the board to a certified pharmacy technician or pharmacy technician trainee is the property of and shall be maintained by the registered pharmacy 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 pharmacy 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; ARC 1785C, IAB 12/10/14, effective 1/14/15]

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 licensed pharmacies located in Iowa that utilize 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. Pharmacy technician training shall be documented and maintained by the pharmacy for the duration of employment. Policies and procedures and documentation of pharmacy technician training shall be available for inspection and copying by the board or an agent of the board.

[ARC 1785C, IAB 12/10/14, effective 1/14/15]

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 rule 657—6.7(124,155A) or 657—7.6(155A), as appropriate, or as provided for telepharmacy in 657—Chapter 13. Except as provided for an approved technician product verification program pursuant to 657—Chapter 40, 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 rule 657—6.7(124,155A) or 657—7.6(155A), as appropriate, or as provided for telepharmacy in 657—Chapter 13.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9783B, IAB 10/5/11, effective 11/9/11; ARC 4189C, IAB 12/19/18, effective 1/23/19; ARC 5007C, IAB 3/25/20, effective 4/29/20]

657—3.22(155A) Technical functions. At the discretion of the supervising pharmacist, the following technical functions, in addition to any of the functions authorized for a pharmacy support person pursuant to 657—Chapter 5, 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 agent.

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 multi-dose and single-dose packages of drugs as provided in 657—Chapter 22.
- i. Perform drug compounding processes as provided in 657—Chapter 20.
- j. 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.
- k. Transfer via oral, facsimile, or electronic means the original prescription drug order information and prescription refill information of a prescription for a noncontrolled substance to a pharmacy as requested by a patient or patient's caregiver pursuant to rule 657—6.9(124,155A). A technician shall not transfer by any means the original prescription drug order information or prescription refill information for a controlled substance.
- l. Receive via oral, facsimile, or electronic means the transfer of original prescription drug order information and prescription refill information of a prescription for a noncontrolled substance from a pharmacy as requested by a patient or patient's caregiver pursuant to rule 657—6.9(124,155A). A technician shall not receive via transfer by any means the original prescription drug order information or prescription refill information of a prescription for a controlled substance.

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 agent.
- 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 multi-dose and single-dose packages of drugs as provided in 657—Chapter 22.
- h. Under the supervision of a pharmacist who provides training and evaluates and monitors trainee competence in the compounding processes, perform drug compounding processes as provided in 657—Chapter 20.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9009B, IAB 8/11/10, effective 7/23/10; ARC 9502B, IAB 5/18/11, effective 6/22/11; ARC 1785C, IAB 12/10/14, effective 1/14/15; ARC 2194C, IAB 10/14/15, effective 11/18/15; ARC 4189C, IAB 12/19/18, effective 1/23/19]

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. Except for a certified pharmacy technician participating in an approved technician product verification program pursuant to 657—Chapter 40, 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 for a controlled substance to another pharmacy or receive the transfer of a prescription drug order for a controlled substance 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; ARC 9783B, IAB 10/5/11, effective 11/9/11; ARC 4189C, IAB 12/19/18, effective 1/23/19; ARC 5007C, IAB 3/25/20, effective 4/29/20]

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 or pharmacy technician trainee 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, 124B, 126, 147, 155A, or 205 or any rule of the board.

An individual whose application for registration as a certified pharmacy technician or pharmacy technician trainee 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; ARC 1785C, IAB 12/10/14, effective 1/14/15; ARC 3857C, IAB 6/20/18, effective 7/25/18]

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, 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 or pharmacy technician trainee registration.
- b. Suspension of a certified pharmacy technician or pharmacy technician trainee registration until further order of the board or for a specified period.
- c. Nonrenewal of a certified 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; ARC 1785C, IAB 12/10/14, effective 1/14/15; ARC 3857C, IAB 6/20/18, effective 7/25/18]

These rules are intended to implement Iowa Code sections 147.72, 147.107, 155A.6A, 155A.23, 155A.33, and 155A.39.

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¹ April 30, 2008, effective date delayed 70 days by the Administrative Rules Review Committee at its meeting held April 4, 2008.

CHAPTER 6
GENERAL PHARMACY PRACTICE
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 2]

657—6.1(155A) Purpose and scope. A general pharmacy is a location where a pharmacist provides pharmaceutical services or dispenses pharmaceutical products to patients in accordance with pharmacy laws. This chapter does not apply to a hospital pharmacy as defined in 657—Chapter 7. The requirements of these rules for general pharmacy practice are in addition to the requirements of 657—Chapter 8 and other rules of the board relating to services provided by the pharmacy.

657—6.2(155A) Pharmacist in charge. One professionally competent, legally qualified pharmacist in charge in each pharmacy shall be responsible for, at a minimum, the responsibilities identified in rule 657—8.3(155A).

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 0501C, IAB 12/12/12, effective 1/16/13; ARC 1961C, IAB 4/15/15, effective 5/20/15]

657—6.3(155A) Reference library. References may be printed or computer-accessed. A reference library shall be maintained which includes, at a minimum, one current reference from each of the following categories, including access to current periodic updates.

1. A reference including all pertinent Iowa laws, rules, and regulations that impact the pharmacy's practice.
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. A reference on natural or herbal medicines.
7. The readily accessible telephone number of a poison control center that serves the area.
8. Additional references as may be necessary for the pharmacist to adequately meet the needs of the patients served.

[ARC 2196C, IAB 10/14/15, effective 11/18/15]

657—6.4(155A) Exemption from duplicate requirements. A pharmacy established in the same location as another licensed pharmacy and with direct and immediate access to required references, patient counseling area, refrigerator, or sink with hot and cold running water may utilize the references, counseling area, refrigerator, or sink of the other pharmacy to satisfy the requirements of rule 657—6.3(155A), subrule 6.14(3), or rule 657—8.5(155A), paragraphs "1" and "2."

657—6.5 and 6.6 Reserved.

657—6.7(124,155A) Security. While on duty, each pharmacist shall be responsible for the security of the prescription department and of the provisions for effective control against theft of, diversion of, or unauthorized access to prescription drugs, including those collected through an authorized collection program, records for such drugs and authorized collection program activities, and patient records as provided in 657—Chapters 10 and 21 and federal regulations for authorized controlled substance collection programs, which can be found at www.deadiversion.usdoj.gov/drug_disposal/.

6.7(1) Department locked. The prescription department shall be locked by key or combination so as to prevent access when a pharmacist is not on site except as provided in subrules 6.7(2) and 6.7(4).

6.7(2) Temporary absence of pharmacist. In the temporary absence of the pharmacist, only the pharmacist in charge may designate pharmacy technicians or pharmacy support persons who may be present in the prescription department to perform technical or nontechnical functions, respectively, designated by the pharmacist in charge. Activities identified in subrule 6.7(3) may not be performed during such temporary absence of the pharmacist. A temporary absence is an absence of short duration not to exceed two hours.

a. In the absence of the pharmacist, the pharmacy shall be secured from public access and the pharmacy shall notify the public that the pharmacist is temporarily absent and that no prescriptions will be dispensed until the pharmacist returns. 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, the pharmacy technician or the pharmacy support person may not dispense or deliver any drug, chemical, device, or prepared prescription to a patient or patient's agent.

b. 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, and documentation of such review shall be maintained for two years from the date of entry.

6.7(3) *Activities prohibited in absence of pharmacist.* Activities which shall not be designated and shall not be performed during the temporary absence of the pharmacist include:

- a. Dispensing or distributing any prescription drugs or devices to patients or others.
- b. Providing the final verification for the accuracy, validity, completeness, or appropriateness of a filled prescription or medication order.
- c. Conducting prospective drug use review or evaluating a patient's medication record for purposes identified in rule 657—8.21(155A).
- d. Providing patient counseling, consultation, or drug information.
- e. Making decisions that require a pharmacist's professional judgment such as interpreting or applying information.
- f. Transferring prescriptions to or from other pharmacies.

6.7(4) *Refill sales during pharmacist break.* At the discretion of the on-duty supervising pharmacist and pursuant to established policies and procedures, the pharmacist may delegate to a technician the dispensing of previously verified prescriptions which have been identified to not require pharmacist counseling pursuant to rule 657—6.14(155A) when the pharmacist is on a break of limited duration and is absent from the pharmacy department.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 1308C, IAB 2/5/14, effective 3/12/14; ARC 2408C, IAB 2/17/16, effective 3/23/16; ARC 3638C, IAB 2/14/18, effective 3/21/18; ARC 4189C, IAB 12/19/18, effective 1/23/19]

657—6.8(124,155A) Prescription processing documentation. All prescriptions shall be dated and assigned a unique identification number that shall be recorded on the original prescription, except as provided in 657—subrule 21.5(1). The original prescription shall be retained by the pharmacy filling the prescription and shall be maintained in the original format as received by the pharmacy. Dispensing documentation shall include the date of fill or refill; the name, strength, and National Drug Code (NDC) of the actual drug product dispensed; and the initials or other unique identification of the pharmacist, pharmacist-intern, or technician in an approved technician product verification program. Dispensing documentation shall be maintained and be readily available.

[ARC 3638C, IAB 2/14/18, effective 3/21/18; ARC 5007C, IAB 3/25/20, effective 4/29/20]

657—6.9(124,155A) Transfer of prescription. The transmission of a prescription drug order from a pharmacy to a pharmacy engaged in centralized prescription filling or processing on behalf of the originating pharmacy pursuant to the requirements of 657—Chapter 18 shall not constitute the transfer of a prescription. Upon the request of a patient or the patient's caregiver, a pharmacy shall transfer original prescription drug order information and prescription refill information to a pharmacy designated by the patient or the patient's caregiver, central fill or processing pharmacies excepted, subject to the following requirements:

6.9(1) *Schedule III, IV, or V prescriptions.* The transfer of original prescription drug order information for controlled substances listed in Schedule III, IV, or V is permissible between pharmacies on a one-time basis except as provided in subrule 6.9(8).

6.9(2) *Noncontrolled substances prescriptions.* The transfer of original prescription drug order information for noncontrolled prescription drugs between pharmacies is permissible as long as the number of transfers does not exceed the number of originally authorized refills and the original prescription is still valid.

6.9(3) *Authorized individuals and means of transmission.* Individuals authorized to engage in the transfer of prescriptions include a pharmacist, a pharmacist-intern under the direct supervision of a pharmacist, and a certified pharmacy technician only as authorized in rule 657—3.22(155A). The transferring individual may transmit the prescription and transfer information required under subrule 6.9(5) from the transferring pharmacy via electronic means pursuant to subrule 6.9(8) or, following direct communication between authorized individuals, via oral or facsimile transmission. The receiving individual shall ensure the prescription transfer record maintained in the receiving pharmacy contains all of the information required under subrule 6.9(7).

6.9(4) *Prescriptions maintained.* Both the original and the transferred prescription drug orders are maintained for a period of two years from the date of last activity.

6.9(5) *Record of transfer out.* The individual transferring the prescription drug order information shall:

- a. Invalidate the prescription drug order;
- b. Record on or with the invalidated prescription drug order the following information:
 - (1) The name, address, and, for a controlled substance, the DEA registration number of the pharmacy to which such prescription is transferred;
 - (2) The name of the individual receiving the prescription drug order information;
 - (3) The name of the individual transferring the prescription drug order information; and
 - (4) The date of the transfer.

6.9(6) *Original prescription status.* The original prescription drug order shall be invalidated in the data processing system for purposes of filling or refilling, but shall be maintained in the data processing system for refill history purposes.

6.9(7) *Record of transfer received.* The individual receiving the transferred prescription drug order information shall:

- a. Indicate that the prescription drug order has been transferred;
- b. Record on or with the transferred prescription drug order the following information:
 - (1) Original date of issuance and date of dispensing, if different from date of issuance;
 - (2) Original prescription number;
 - (3) Number of valid refills remaining, the date of last refill, and, for a controlled substance, the dates and locations of all previous refills;
 - (4) Name, address, and, for a controlled substance, the DEA registration number of the pharmacy from which such prescription drug order information is transferred;
 - (5) The date of the transfer;
 - (6) Name of the individual receiving the prescription drug order information;
 - (7) Name of the individual transferring the prescription drug order information; and
 - (8) If transferring a controlled substance prescription from a pharmacy utilizing a shared electronic database system as described in subrule 6.9(8) to a pharmacy outside that shared system, the pharmacy name, location, DEA registration number, and prescription number from which the prescription was originally filled.

6.9(8) *Electronic transfer between pharmacies.* Pharmacies may electronically transfer prescription information, including controlled substance prescription information in compliance with federal regulations for controlled substances. For transfers of prescriptions for noncontrolled substances and controlled substances, pharmacies that share a real-time, online database may transfer up to the maximum refills permitted by law and the prescriber's authorization. A prescription for a controlled substance transferred between two pharmacies which do not share a real-time, online database may only be transferred one time.

[ARC 7634B, IAB 3/11/09, effective 4/15/09; ARC 8169B, IAB 9/23/09, effective 10/28/09; ARC 0343C, IAB 10/3/12, effective 11/7/12; ARC 3638C, IAB 2/14/18, effective 3/21/18; ARC 4189C, IAB 12/19/18, effective 1/23/19]

657—6.10(126,155A) Prescription label requirements.

6.10(1) Required information. The label affixed to or on the dispensing container of any prescription drug or device dispensed by a pharmacy pursuant to a prescription drug order shall bear the following:

- a. Serial number (a unique identification number of the prescription);
- b. The name, telephone number, and address of the pharmacy;
- c. The name of the patient or, if such drug is prescribed for an animal, the species of the animal and the name of its owner, except as provided in 657—subrule 8.19(7) for epinephrine auto-injectors, 657—subrule 8.19(8) for opioid antagonists, or 657—subrule 8.19(9) for expedited partner therapy.
- d. The name of the prescribing practitioner;
- e. The date the prescription is dispensed;
- f. The directions or instructions for use, including precautions to be observed;
- g. Unless otherwise directed by the prescriber, the label shall bear the name, strength, and quantity of the drug dispensed.

(1) If a pharmacist selects an equivalent drug product for a brand name drug product prescribed by a practitioner, the prescription container label shall identify the generic drug and may identify the brand name drug for which the selection is made, such as “(generic name) Generic for (brand name product)”;

(2) If a pharmacist selects a brand name drug product for a generic drug product prescribed by a practitioner, the prescription container label shall identify the brand name drug product dispensed and may identify the generic drug product ordered by the prescriber, such as “(brand name product) for (generic name)”;

(3) If a pharmacist selects an interchangeable biological product for the biological product prescribed by a practitioner, the prescription container label shall identify the interchangeable biological product dispensed and may identify the biological product prescribed by the practitioner, such as “(interchangeable biological product) for (biological product)”;

h. The initials or other unique identification of the dispensing pharmacist, unless the identification of the pharmacist involved in each step of the prescription filling process is electronically documented and retrievable.

6.10(2) Exceptions. The requirements of subrule 6.10(1) do not apply to unit dose dispensing systems, 657—22.1(155A), and patient med paks, 657—22.5(126,155A).

[ARC 2194C, IAB 10/14/15, effective 11/18/15; ARC 2414C, IAB 2/17/16, effective 3/23/16; ARC 3638C, IAB 2/14/18, effective 3/21/18; ARC 4903C, IAB 2/12/20, effective 3/18/20]

657—6.11 and 6.12 Reserved.

657—6.13(155A) Patient record system.

6.13(1) Information required. A patient record system shall be maintained by all pharmacies for patients for whom prescription drug orders are dispensed. The patient record system shall contain, at a minimum, the following information:

- a. Full name of the patient;
- b. Address and telephone number of the patient;
- c. Patient’s date of birth;
- d. Patient’s gender;
- e. Known allergies;
- f. A list of all prescription drug orders dispensed by the pharmacy during the two years immediately preceding the most recent entry showing the name of the drug or device, prescription number, name and strength of the drug, the quantity and date dispensed, and the name of the prescriber; and
- g. Pharmacist comments relevant to the patient’s health care, including:
 - (1) Known drug reactions,
 - (2) Identified idiosyncrasies,
 - (3) Known chronic conditions or disease states of the patient,

(4) The identity of any other drugs, over-the-counter drugs, herbals, supplements, other alternative medications, or devices currently being used by the patient that may relate to prospective drug review.

6.13(2) *Record retained.* A patient record shall be maintained for a period of not less than two years from the date of the last entry in the patient record. This record may be a hard copy or a computerized form.

6.13(3) *Confidential.* Information in the patient record shall be deemed to be confidential and may be released only as provided in rule 657—8.16(124,155A).

6.13(4) *Expedited partner therapy.* When a pharmacy dispenses a prescription drug pursuant to Iowa Code section 139A.41 and 657—subrule 8.19(9) for expedited partner therapy, a pharmacy is only required to maintain the information about the patient who is known to the pharmacy.

[ARC 3638C, IAB 2/14/18, effective 3/21/18; ARC 4903C, IAB 2/12/20, effective 3/18/20]

657—6.14(155A) Patient counseling and instruction. Every pharmacy that is open to the public and located in Iowa shall post in every prescription pickup area, including in every drive-through prescription pickup lane, in a manner clearly visible to patients, a notice that Iowa law requires the pharmacist to discuss with the patient any prescriptions dispensed to the patient that are new or a change in drug therapy.

6.14(1) *Counseling required.* Upon receipt of a new prescription drug order, or upon receipt of a change in drug therapy including but not limited to a change of dose, directions, or drug formulation, and following a prospective drug use review pursuant to rule 657—8.21(155A), a pharmacist or pharmacist-intern shall counsel each patient or patient's caregiver. An offer to counsel shall not fulfill the requirements of this rule. Patient counseling shall be on matters which, in the pharmacist's professional judgment, will enhance or optimize drug therapy. Appropriate elements of patient counseling may include:

- a. The name and description of the drug;
- b. The dosage form, dose, route of administration, and duration of drug therapy;
- c. Intended use of the drug, if known, and expected action;
- d. Special directions and precautions for preparation, administration, and use by the patient;
- e. Common severe side effects or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;
- f. Techniques for self-monitoring drug therapy;
- g. Proper storage;
- h. Prescription refill information;
- i. Action to be taken in the event of a missed dose;
- j. Pharmacist comments relevant to the individual's drug therapy including any other information peculiar to the specific patient or drug.

6.14(2) *Instruction.* A pharmacist may instruct patients and demonstrate procedures for self-monitoring of medical conditions and for self-administration of drugs.

6.14(3) *Counseling area.* A pharmacy shall contain an area which is suitable for confidential patient counseling. Such area shall:

- a. Be easily accessible to both patient and pharmacists and not allow patient access to prescription drugs;
- b. Be designed to maintain the confidentiality and privacy of the pharmacist/patient communication.

6.14(4) *Oral counseling not practicable.* If in the pharmacist's professional judgment oral counseling is not practicable, the pharmacist may select and use alternative forms of patient information which shall include information for the patient or patient's caregiver to contact the pharmacist for further consultation. The manner in which the patient or caregiver contacts the pharmacist shall not cause the patient to incur any expense. "Not practicable" refers to patient variables including, but not limited to, the absence of the patient or patient's caregiver, the patient's or caregiver's hearing impairment, or a language barrier. "Not practicable" does not include pharmacy variables such as

inadequate staffing, technology failure, or high prescription volume. A combination of oral counseling and alternative forms of counseling is encouraged.

6.14(5) *Exception.* Patient counseling, as described above, shall not be required for inpatients of an institution where other licensed health care professionals are authorized to administer the drugs.

6.14(6) *Refusal of consultation.* A pharmacist shall not be required to counsel a patient or caregiver when the patient or caregiver refuses such consultation. A patient's or caregiver's refusal of consultation shall be documented by the pharmacist. The absence of any record of a refusal of the pharmacist's attempt to counsel shall be presumed to signify that counseling was provided.

[ARC 8540B, IAB 2/24/10, effective 4/1/10; ARC 9910B, IAB 12/14/11, effective 1/18/12; ARC 3638C, IAB 2/14/18, effective 3/21/18]

657—6.15(124,126) Return of drugs and devices. For the protection of the public health and safety, prescription drugs and devices may be returned to the pharmacy for reuse or resale only as herein provided:

6.15(1) *Integrity maintained.* Prescription drugs and devices may be returned, exchanged, or resold only if, in the professional judgment of the pharmacist, the integrity of the prescription drug or device has not in any way been compromised.

6.15(2) *Controlled substances.* Under no circumstances shall pharmacy personnel accept from a patient or a patient's agent any controlled substances for return, exchange, or resale except to the same patient.

6.15(3) *Unit dose returns.* Prescription drugs dispensed in unit dose packaging, excluding controlled substances, may be returned and reused as authorized in 657—subrule 22.1(6).

[ARC 3638C, IAB 2/14/18, effective 3/21/18]

657—6.16(124,155A) Records. Every record required to be kept under Iowa Code chapters 124 and 155A or rules of the board 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 the record or last activity except as specifically identified by law or rule. Controlled substances records shall be maintained in a readily retrievable manner in accordance with federal requirements and 657—Chapter 10.

6.16(1) *Combined records.* If controlled substances, prescription drugs, or nonprescription drug items are listed on the same record, the controlled substances shall be asterisked, red-lined, or in some other manner made readily identifiable from all other items appearing on the records.

6.16(2) *Storage of records.* Original hard-copy prescriptions and other pharmacy records shall be maintained by the pharmacy for a minimum of two years from the date of the record in accordance with this subrule.

a. Records shall be maintained within the licensed pharmacy department for a minimum of 12 months, except as provided herein. Pharmacy records less than 12 months old may be stored in a secure storage area outside the licensed pharmacy department, including at a remote location, if the pharmacy has retained an electronic copy of the records in the pharmacy that is immediately available and if the original records are available within 72 hours of a request by the board or its authorized agent, unless such remote storage is prohibited under federal law.

b. Records more than 12 months old may be maintained in a secure storage area outside the licensed pharmacy department, including at a remote location, if the records are retrievable within 72 hours of a request by the board or its authorized agent, unless such remote storage is prohibited under federal law.

6.16(3) *Number imprinted.* The original hard-copy prescription shall be imprinted with the prescription or control number assigned to the prescription drug order, except as provided in 657—subrule 21.5(1).

6.16(4) *Alternative data retention system.* Records, except when specifically required to be maintained in original or hard-copy form, may be maintained in an alternative data retention system, such as a data processing system or direct imaging system provided:

a. The records maintained in the alternative system contain all of the information required on the manual record;

b. The data processing system is capable of producing a hard copy of the record, within two business days, upon the request of the board, its representative, or other authorized local, state, or federal law enforcement or regulatory agencies; and

c. The information maintained in the alternative system is not obscured or rendered illegible due to security features of the original record.

[ARC 7636B, IAB 3/11/09, effective 4/15/09; ARC 8539B, IAB 2/24/10, effective 4/1/10; ARC 3638C, IAB 2/14/18, effective 3/21/18; ARC 5007C, IAB 3/25/20, effective 4/29/20]

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.

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◊ Two or more ARCs

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 illnesses to which patients 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.

[ARC 9911B, IAB 12/14/11, effective 1/18/12]

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 responsibilities identified in rule 657—8.3(155A). Where 24-hour operation of the pharmacy is not feasible, a pharmacist shall be available on an “on call” basis.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 1961C, IAB 4/15/15, effective 5/20/15]

657—7.3(155A) Reference library. A pharmacy shall maintain a reference library which is either printed or computer-accessed and which adequately meets the needs of the services provided and patients served. Examples of such references include:

1. A reference including all pertinent Iowa laws, rules, and regulations that impact the pharmacy’s practice.
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 drug 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 relating to specific patient populations served, such as pediatrics or geriatrics, or disease states treated, such as oncology or infectious disease.

[ARC 2196C, IAB 10/14/15, effective 11/18/15; ARC 4267C, IAB 1/30/19, effective 3/6/19]

657—7.4 Reserved.

657—7.5(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 and under the control of the pharmacy:

7.5(1) Pharmacy department security. Policies and procedures shall identify measures to ensure the security of the pharmacy department, 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, including when the pharmacist is absent from the pharmacy department or absent from the facility pursuant to rule 657—7.6(155A).

7.5(2) Security outside the pharmacy department. Policies and procedures shall identify measures to ensure security in areas outside the pharmacy department where drugs, including controlled

substances, devices, drug records, and patient records are maintained or stored, including provisions for effective control against theft of, diversion of, or unauthorized access to such drugs and records.

7.5(3) *Authorized collection program.* Receptacles that are located in the hospital for the authorized collection of controlled substances shall be secured pursuant to 657—Chapter 10 and federal regulations for disposal of controlled substances.

7.5(4) *System security.* Electronic systems shall be secured to prevent unauthorized access. System login or access credentials issued to an authorized system user shall not be shared with or disclosed to any other individual.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9408B, IAB 3/9/11, effective 4/13/11; ARC 1308C, IAB 2/5/14, effective 3/12/14; ARC 2408C, IAB 2/17/16, effective 3/23/16; ARC 4267C, IAB 1/30/19, effective 3/6/19]

657—7.6(155A) Pharmacist absence.

7.6(1) *Pharmacist absent from the pharmacy department.* A pharmacy's policies and procedures shall identify how the pharmacy will operate and be secured to prevent unauthorized access during times when the pharmacist may be absent from the pharmacy department but not absent from the facility. The policies and procedures shall also identify authorized activities of pharmacy staff in the pharmacy department during the absence of the pharmacist from the department in compliance with rules of the board.

a. Remote pharmacy services. Pursuant to rule 657—7.7(155A), the pharmacy may utilize the services of a remote pharmacist or pharmacy to provide pharmacist services to assist the pharmacy department while the on-site pharmacist is absent from the pharmacy department, such as when participating in clinical activities with facility staff and patients.

b. Certified pharmacy technicians. Pursuant to the pharmacy's policies and procedures, a certified pharmacy technician may be granted access to the pharmacy department to perform authorized technical functions. In the absence of a pharmacist, a certified pharmacy technician may only dispense, deliver, or distribute a drug, including a compounded preparation and controlled substance, when the drug is verified by a pharmacist, including by a remote pharmacist, except as authorized in an approved technician product verification program. A certified pharmacy technician may assist a licensed health care professional in locating a drug to meet the emergent needs of a patient but shall not provide final verification of the accuracy of the drug product obtained.

c. Pharmacy support persons. Pursuant to the pharmacy's policies and procedures, a pharmacy support person may be granted access to the pharmacy department to perform authorized nontechnical functions.

d. Licensed health care professionals. Pursuant to the pharmacy's policies and procedures, a licensed health care professional may be granted access to the pharmacy department to meet the emergent needs of a patient. A licensed health care professional may utilize the assistance of a certified pharmacy technician to locate a drug but shall not rely on the technician to verify the accuracy of the drug product obtained.

7.6(2) *Pharmacy department closed.* When the pharmacist is absent from the facility, the pharmacy department shall be closed and secured to prevent unauthorized access. The pharmacist in charge shall identify in policies and procedures the facility and pharmacy staff, by title or designation, who are authorized access to the pharmacy department and the specific activities that are authorized.

a. Remote pharmacy services. Pursuant to rule 657—7.7(155A), the pharmacy may utilize the services of a remote pharmacist or pharmacy to provide pharmacist services to the facility when the pharmacy is closed.

b. Certified pharmacy technicians. Pursuant to the pharmacy's policies and procedures, a certified pharmacy technician may be granted access to the pharmacy department to perform authorized technical functions. In the absence of a pharmacist, a certified pharmacy technician may only dispense, deliver, or distribute a drug, including a compounded preparation and controlled substance, when the drug is verified by a pharmacist, including by a remote pharmacist. During each period of time the certified pharmacy technician is working in the pharmacy without pharmacist supervision, the technician shall document the time worked and activities performed. The documentation shall be periodically reviewed by the

pharmacist in charge. A certified pharmacy technician may assist a licensed health care professional in locating a drug to meet the emergent needs of a patient but shall not provide the final verification of the accuracy of the drug obtained.

c. Pharmacy support persons. Pursuant to the pharmacy's policies and procedures, a pharmacy support person may be granted access to the pharmacy department to perform authorized nontechnical functions. During each period of time the pharmacy support person is working in the pharmacy without pharmacist supervision, the support person shall document the time worked and activities performed. The documentation shall be periodically reviewed by the pharmacist in charge.

d. Licensed health care professionals. Pursuant to the pharmacy's policies and procedures, a licensed health care professional may be granted access to the pharmacy department to meet the emergent needs of a patient. A licensed health care professional may utilize the assistance of a certified pharmacy technician to locate a drug but shall not rely on the technician to verify the accuracy of the drug product obtained. The pharmacy shall maintain documentation of such access and activities.

This rule is intended to implement Iowa Code sections 124.301, 147.76, 147.107, and 155A.33.
[ARC 4267C, IAB 1/30/19, effective 3/6/19; ARC 5007C, IAB 3/25/20, effective 4/29/20]

657—7.7(155A) Verification by remote pharmacist. A hospital pharmacy may contract with an Iowa-licensed pharmacy or pharmacist for remote pharmacist services, including medication order entry and review, final product verification, and provision of drug information. Pharmacies and pharmacists 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 on-site hospital pharmacy services and are not intended to eliminate the need for an on-site hospital pharmacy or pharmacist. The activities authorized by this rule are intended to increase the availability of the pharmacist for involvement in clinical patient care activities when the pharmacy is open or to continue the provision of pharmacy services when the pharmacy is closed. The hospital pharmacy shall maintain records that demonstrate the directing of pharmacist activities to additional clinical patient care activities, and those records shall be available for inspection by the board or its authorized agent.

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 pharmacist services identified in this chapter in compliance with this rule.

7.7(3) Licenses required. A pharmacy or pharmacist contracting with a hospital pharmacy to provide services pursuant to this rule shall maintain with the board a current Iowa pharmacy license or pharmacist license, respectively. 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) Remote access requirements. A pharmacist providing services from a remote location shall:

- a.* Have secure electronic access to the hospital's patient information system on which the pharmacist has been adequately trained,
- b.* Have access to the patient's health care team to discuss any concerns identified during the pharmacist's review of the patient's information or medication order,
- c.* Have secure access to any other electronic systems the pharmacist would otherwise have access to in the facility,
- d.* Have access to sufficient references to adequately meet the needs of the patients served, and
- e.* When involved in review or verification, be identified, by name or unique identifier and function performed, on the drug or device order.

[ARC 9408B, IAB 3/9/11, effective 4/13/11; ARC 0502C, IAB 12/12/12, effective 1/16/13; ARC 4267C, IAB 1/30/19, effective 3/6/19]

657—7.8(124,126,155A) Drug distribution and control. Policies and procedures governing drug distribution and control shall be established pursuant to rule 657—8.3(155A) 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. Control and adequate quality assurance procedures needed to ensure that patients receive the correct drugs at the proper times shall be established pursuant to rule 657—8.3(155A).

a. Hospitals shall utilize a unit dose dispensing system pursuant to rule 657—22.1(155A). All drugs dispensed by the pharmacy 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) Established policies and procedures shall 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. All sterile and nonsterile compounded products shall be prepared in conformance with 657—Chapter 20.

7.8(2) Medication orders. Except to meet the emergent needs of a patient, no drug or device shall be dispensed or made available for patient administration prior to the issuance of a valid medication order and appropriate pharmacist review.

a. Verbal order. The use of verbal orders shall be minimized. All verbal orders shall be read back to the prescriber, and the read back shall be documented with or on the order.

b. Written order not entered by prescriber. If an individual other than the prescriber enters a medication order into an electronic medical record system from an original written medication order, a pharmacist shall review and verify the entry against the original written order before the drug is dispensed or made available for administration except for emergency use, when the pharmacy is closed, or as provided in rule 657—7.7(155A).

c. Order entered when pharmacy closed. When the pharmacy is closed and remote pharmacist services are not available, 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, except when a pharmacist entered the order, a pharmacist shall verify the entry against the original written medication order, if such written order exists, as soon as practicable.

d. Abbreviations and chemical symbols on orders. 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(3) Stop order. A policy concerning stop orders shall be established to ensure that medication orders are not inappropriately continued.

7.8(4) Emergency drug supplies and floor stock. Pursuant to policies and procedures, supplies of drugs for use in medical emergencies shall be immediately available. All drug storage areas within the facility shall be routinely inspected to ensure that no outdated or unusable items are available for administration and that all stock items are properly labeled and stored.

7.8(5) 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(6) Drugs brought into the facility. Established policies and procedures shall determine those circumstances when patient-owned drugs brought into the facility may be administered to the patient and shall identify procedures governing the use and security of drugs brought into the facility. Procedures shall address identification of the drug and methods for ensuring the integrity of the product prior to permitting its use. The use of patient-owned drugs shall be minimized to the greatest extent possible.

7.8(7) Samples. The use of drug samples within the institution shall be eliminated to the extent possible. Sample use is prohibited for hospital inpatient use. For the purposes of this subrule, “samples” shall not include initiation doses provided by a manufacturer’s long-acting antipsychotic medication initiation program.

7.8(8) Investigational drugs. If investigational drugs are used in the facility:

- a. A pharmacist shall be a member of the institutional review board or its equivalent.
- b. The pharmacy shall be responsible, in cooperation with the principal investigator, for providing information about investigational drugs used in the facility and for the distribution and control of those drugs.

7.8(9) Hazardous drugs and chemicals. Policies and procedures for handling drugs and chemicals that are known occupational hazards shall be established pursuant to rule 657—8.3(155A). The procedures shall maintain the integrity of the drug or chemical and protect facility personnel.

7.8(10) Leave and discharge meds. Labeling of medications for a patient on leave from the facility for a period in excess of 24 hours or being discharged from the facility shall comply with 657—subrule 6.10(1).

7.8(11) Own-use outpatient prescriptions. If the hospital pharmacy dispenses own-use outpatient prescriptions, the pharmacist shall comply with all requirements of 657—Chapter 6 except rule 657—6.1(155A).

7.8(12) Influenza and pneumococcal vaccines. As authorized by federal law, a patient-specific medication order shall not be required prior to administration to an adult patient of influenza and pneumococcal vaccines pursuant to physician-approved facility policy and after the patient has been assessed for contraindications. Administration shall be recorded in the patient's medical record.

7.8(13) Accountability of stock supply. An individual who administers a controlled substance from a non-patient-specific stock supply in a facility 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 or unique electronic signature or identification of a witnessing licensed health care practitioner. Distribution records for non-patient-specific floor-stocked controlled substances shall include the following information:

- a. Patient's name;
- b. Prescriber who ordered the drug;
- c. Drug name, strength, dosage form, and quantity;
- d. Date and time of administration;
- e. Signature or unique electronic signature of the individual administering the controlled substance;
- f. Returns to the pharmacy;
- g. Waste, which is required to be witnessed and cosigned by another licensed health care practitioner.

[ARC 8170B, IAB 9/23/09, effective 10/28/09; ARC 9911B, IAB 12/14/11, effective 1/18/12; ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 2194C, IAB 10/14/15, effective 11/18/15; ARC 2197C, IAB 10/14/15, effective 11/18/15; ARC 4267C, IAB 1/30/19, effective 3/6/19]

657—7.9(124,155A) Drug information. Established policies and procedures shall include the provision to the facility's staff and patients of accurate, comprehensive information about drugs and their use. The pharmacy shall serve as the facility's center for drug information.

[ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 4267C, IAB 1/30/19, effective 3/6/19]

657—7.10(124,155A) Ensuring rational drug therapy. An important aspect of pharmaceutical services is that of maximizing rational drug use. Policies and procedures for ensuring the quality of drug therapy shall be established pursuant to rule 657—8.3(155A). For the purpose of this rule, "professional pharmacy staff" means the professional employees of the pharmacy, including pharmacists, pharmacy technicians, and pharmacist-interns.

7.10(1) Patient profile. The pharmacy shall maintain for each patient receiving care at the hospital a patient profile, to include but not be limited to drug history. Sufficient patient information to ensure meaningful and effective patient care shall be collected, maintained, and reviewed by professional pharmacy staff pursuant to policies and procedures. Appropriate clinical information about patients shall be available and accessible to the pharmacist for use in daily practice. Upon review of a patient's

current clinical profile, the pharmacist shall directly communicate any suggested changes to the patient's health care team.

7.10(2) Adverse drug events. Established policies and procedures shall include a mechanism for the reporting of adverse drug events that occur in the facility which events are reviewed by the facility's established quality control committee. The pharmacist shall be informed of all reported adverse drug events occurring in the facility. Adverse drug events include but are not limited to adverse drug reactions and medication errors.

[ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 4267C, IAB 1/30/19, effective 3/6/19]

657—7.11(124,126,155A) Outpatient services. No prescription drugs shall be dispensed from the hospital pharmacy to patients treated in a hospital outpatient setting. If a need is established for the dispensing of a prescription drug to an outpatient, a prescription shall be issued 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 a patient who is examined and evaluated in the emergency department.

"Outpatient" means a patient who was examined and evaluated by a prescriber who determined the patient's need for the administration of a drug or device, when the patient 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 an order issued by a prescriber pursuant to rules of the board 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. Established policies and procedures shall include a system of drug control and accountability 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 have a controlled substance administered, 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 other than the outpatient setting, the prescriber shall issue a prescription or order for administration of the drug in 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 issued pursuant to federal regulation and board rules and, except as provided in rule 657—10.29(124) regarding the issuance of multiple Schedule II prescriptions, may authorize the administration of an appropriate amount of the prescribed substance for a period not to exceed 90 days from the date ordered.

(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 issued pursuant to federal regulation and board rules 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.

7.11(3) Samples. 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 facility's appropriate patient care committee, subject to oversight by the pharmacy.

[ARC 8909B, IAB 6/30/10, effective 8/4/10; ARC 0243C, IAB 8/8/12, effective 9/12/12; ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 4267C, IAB 1/30/19, effective 3/6/19]

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 a patient who is examined and evaluated in the emergency department and includes the partner or partners of a patient treated pursuant to Iowa Code section 139A.41.

7.12(1) Accountability. Established policies and procedures shall include a system of drug control and accountability in the emergency department. The system shall identify drugs of the nature and type to meet the emergency needs of 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 for the administration of a controlled substance for which the prescriber has issued a prescription in compliance with federal regulation and board rules. 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. Only a pharmacist or prescriber may dispense any drugs to an emergency department patient pursuant to the provisions of this rule.

a. Responsibility. Pursuant to rule 657—8.3(155A), policies and procedures shall be established to ensure the accuracy and labeling of prepackaged drugs and accurate records of dispensing of drugs from the emergency department shall be maintained.

(1) Except as provided in subrule 7.12(4), drugs dispensed to an emergency department patient may be dispensed in quantities not to exceed a 72-hour supply or the minimum quantity in suitable containers, except that an authorized supply of a drug provided through the department of public health 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) 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 the 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, including when any portion of the dispensing process is delegated to a licensed nurse under the supervision of the prescriber.

(1) Except as provided in subrule 7.12(4), at the time of delivery of the drug the prescriber shall be responsible for ensuring 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, except when the drug is dispensed for one or more unnamed partners receiving expedited partner therapy pursuant to Iowa Code section 139A.41;
5. Directions for use; and
6. Name, quantity, and strength of drug.

(2) 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, packaged 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 issue a prescription for the additional quantities to be filled at a pharmacy of the patient's choice.

7.12(4) *Use of an outpatient point-of-care automated dispensing system (OPCADS).* 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 utilize an outpatient point-of-care automated dispensing system (OPCADS) in the emergency department only as provided by this subrule. For the purpose of this rule, an OPCADS is a secure dispensing system which contains prepackaged medications verified by authorized pharmacy personnel for dispensing to a patient upon issuance of a valid prescription by a prescriber. The OPCADS shall be owned by the facility, shall be operated under the facility's hospital pharmacy license, shall not be issued a separate general or limited use pharmacy license, and shall not provide any financial incentive for use to any prescriber employed or under contract with the emergency department.

a. Persons with access to the OPCADS for the purposes of stocking, inventory, and monitoring shall be limited to pharmacists, pharmacy technicians, and pharmacist-interns.

b. The OPCADS shall be used only in the emergency department for the benefit of patients examined or treated in the emergency department when the benefit to the patient outweighs the burden on the patient to obtain the medication elsewhere.

c. The OPCADS shall be located in a secure and professionally appropriate environment.

d. The stock of drugs maintained and dispensed utilizing the OPCADS 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 OPCADS shall be appropriately labeled as provided in 657—paragraphs 6.10(1)“a” through “g.”

f. Prior to authorizing the dispensing of a drug utilizing the OPCADS, the prescriber shall offer to issue the patient a prescription that may be filled at a pharmacy of the patient's choice.

g. During consultation with the patient or the patient's caregiver, the prescriber or licensed nurse under the supervision of the prescriber shall clearly explain the appropriate use of the drug supplied. If additional quantities of the drug are required to complete the needed course of treatment, the prescriber shall issue a prescription for the additional quantity to be filled at a pharmacy of the patient's choice.

h. The pharmacy shall, in conjunction with the emergency department, implement policies and procedures to ensure that a patient utilizing the OPCADS has been positively identified.

[ARC 8909B, IAB 6/30/10, effective 8/4/10; ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 4267C, IAB 1/30/19, effective 3/6/19; ARC 4903C, IAB 2/12/20, effective 3/18/20]

657—7.13(124,155A) Records. Every 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 authorized agent for at least two years from the date of such record unless a longer retention period is specified for the particular record.

7.13(1) Medication order information. Each original medication order contained in inpatient records shall include the following information:

- a.* Patient name and identification number;
- b.* Drug name, strength, and dosage form;
- c.* Directions for use;
- d.* Date ordered;
- e.* Prescriber's signature or electronic signature or that of the prescriber'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.

7.13(4) Storage of records. Original hard-copy records shall be maintained by the pharmacy for a minimum of two years from the date of the record in accordance with this subrule.

a. Records shall be maintained within the pharmacy department for a minimum of 12 months, except as provided herein. Pharmacy records less than 12 months old may be stored in a secure storage area outside the pharmacy department, including at a remote location, if the pharmacy has retained an electronic copy of the records in the pharmacy that is immediately available and if the original records are available within 72 hours of a request by the board or its authorized agent, unless such remote storage is prohibited under federal law.

b. Records more than 12 months old may be maintained in a secure storage area outside the pharmacy department, including at a remote location, if the records are retrievable within 72 hours of a request by the board or its authorized agent, unless such remote storage is prohibited under federal law. [ARC 4267C, IAB 1/30/19, effective 3/6/19; ARC 5007C, IAB 3/25/20, effective 4/29/20]

These rules are intended to implement Iowa Code sections 124.301, 124.303, 124.306, 124.308, 126.10, 126.11, 155A.6A, 155A.6B, 155A.7, 155A.13, 155A.15, 155A.27, 155A.28, 155A.31 through 155A.36, 155A.38, 155A.41, 155A.43, and 155A.44.

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[Filed ARC 9408B (Notice ARC 9183B, IAB 11/3/10), IAB 3/9/11, effective 4/13/11]
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[Filed ARC 0243C (Notice ARC 0075C, IAB 4/4/12), IAB 8/8/12, effective 9/12/12]
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[Filed ARC 3345C (Notice ARC 3136C, IAB 6/21/17), IAB 9/27/17, effective 11/1/17]
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[Filed ARC 4903C (Notice ARC 4693C, IAB 10/9/19), IAB 2/12/20, effective 3/18/20]
[Filed ARC 5007C (Notice ARC 4695C, IAB 10/9/19), IAB 3/25/20, effective 4/29/20]

◇ 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 purpose of this chapter is to establish the minimum standards of pharmacy practice for the activities identified in this chapter. The requirements of these rules shall apply to all Iowa-licensed pharmacists, other registered pharmacy personnel, and all pharmacies, including owners, providing the services addressed in this chapter to patients in Iowa. These rules are in addition to rules of the board relating to specific types of pharmacy licenses issued by the board unless otherwise indicated by rule.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.2(155A) Definitions. For the purpose of this chapter, the following definitions shall apply:

“*Board*” means the Iowa board of pharmacy.

“*Confidential information*” means information accessed or maintained by the pharmacy in the patient’s or the pharmacy’s records which contains personally identifiable information that could be used to identify the patient. “Confidential information” 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.

“*DEA*” means the United States Department of Justice, Drug Enforcement Administration.

“*Pharmacy support person*” or “*PSP*” means a person, other than a member of the professional pharmacy staff, registered with the board who may perform nontechnical duties assigned by a supervising pharmacist under the pharmacist’s responsibility and supervision.

“*Professional pharmacy staff*” shall mean the professional employees of the pharmacy, including pharmacists, pharmacy technicians, and pharmacist-interns.

This rule is intended to implement Iowa Code chapter 155A.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.3(155A) Responsible parties.

8.3(1) Pharmacist in charge. One professionally competent, legally qualified pharmacist in charge in each pharmacy shall work cooperatively with the pharmacy, by and through its owner or license holder, and with all staff pharmacists to ensure 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. A part-time pharmacist in charge has the same obligations and responsibilities as a full-time pharmacist in charge.

8.3(2) Pharmacy. Each pharmacy, by and through its owner or license holder, shall work cooperatively with the pharmacist in charge and with all staff pharmacists to ensure 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. The pharmacy, by and through its owner or license holder, shall be responsible for employing a professionally competent, legally qualified pharmacist in charge. The pharmacy, by and through its owner or license holder, may be held responsible for unethical conduct or practices of any of the pharmacy staff.

8.3(3) Pharmacy and pharmacist in charge. The pharmacist in charge and the pharmacy, by and through its owner or license holder, shall share responsibility for, at a minimum, the following:

a. Ensuring that the pharmacy employs an adequate number of qualified personnel commensurate with the size and scope of services provided by the pharmacy.

b. Ensuring the availability of any equipment and references necessary for the particular practice of pharmacy.

c. Ensuring that there is adequate space within the prescription department or a locked room not accessible to the public for the storage of prescription drugs, including controlled substances, devices, and pharmacy records, and to support the operations of the pharmacy.

d. Ensuring that the license, registration, or certification of each professional pharmacy staff member and the registration of each pharmacy support person are maintained in current and active status.

8.3(4) *Pharmacist in charge and staff pharmacists.* The pharmacist in charge and staff pharmacists shall share responsibility for, at a minimum, the following:

a. Ensuring that a pharmacist performs prospective drug use review as specified in rule 657—8.21(155A).

b. Ensuring that a pharmacist or pharmacist-intern provides patient counseling as specified in rule 657—6.14(155A).

c. Dispensing drugs to patients, including the packaging, preparation, compounding, and labeling functions performed by pharmacy personnel.

d. Delivering drugs to the patient or the patient's agent.

e. Ensuring that patient medication records are maintained as specified in rule 657—6.13(155A).

f. Training and supervising pharmacist-interns, pharmacy technicians, pharmacy support persons, and other pharmacy employees.

g. Procuring and storing prescription drugs and devices and other products dispensed from the pharmacy.

h. Distributing and disposing of drugs from the pharmacy.

i. 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.

j. 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.

8.3(5) *Pharmacy, pharmacist in charge, and staff pharmacists.* The pharmacy, by and through its owner or license holder, the pharmacist in charge, and all staff pharmacists shall share responsibility for, at a minimum, the following:

a. Establishing and periodically reviewing (by the pharmacy and the pharmacist in charge), implementing (by the pharmacist in charge), and complying (by the pharmacist in charge and staff pharmacists) with policies and procedures for all operations of the pharmacy. The policies and procedures shall identify the frequency of review.

b. Establishing and maintaining effective controls against the theft or diversion of prescription drugs, including controlled substances, and records for such drugs.

c. Establishing (by the pharmacy and the pharmacist in charge), implementing (by the pharmacist in charge), and utilizing (by the pharmacist in charge and staff pharmacists) an ongoing, systematic program of continuous quality improvement for achieving performance enhancement and ensuring the quality of pharmaceutical services.

8.3(6) *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.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 1576C, IAB 8/20/14, effective 9/24/14; ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.4(155A) Pharmacist identification and staff logs.

8.4(1) *Display of pharmacist license.* During any period a pharmacist is working in a pharmacy, each pharmacist shall display, in a position visible to the public, an original license to practice pharmacy in Iowa. 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) *Registration maintained of pharmacy personnel.* Each pharmacist-intern, pharmacy technician, and pharmacy support person shall maintain current registration with the board. The registration certificate or a copy of the registration certificate shall be readily retrievable upon request of the board or its authorized agent.

8.4(3) Identification codes. A permanent log of the initials or identification code identifying by name each 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(4) 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(5) Identification. While on duty, pharmacy personnel shall wear visible identification that clearly identifies the person by licensed or registered title and includes at least the person's first name.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9409B, IAB 3/9/11, effective 4/13/11; ARC 3858C, IAB 6/20/18, effective 7/25/18]

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 pursuant to rule 657—8.3(155A). Space and equipment shall be available in an amount and type to provide secure, environmentally controlled storage of drugs.

8.5(1) Refrigeration. The pharmacy shall maintain one or more refrigeration units, unless the pharmacy does not stock refrigerated items. The pharmacy shall document verification that the temperature of the refrigerator is maintained within a range compatible with the proper storage of drugs requiring refrigeration. If the temperature is manually or visually verified, a record of minimum daily verification shall be maintained.

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. A 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—7.5(124,155A). To ensure that secure closure, 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.

8.5(4) Remodel or relocation—inspection. A pharmacy planning to remodel or relocate a licensed pharmacy department on or within the premises currently occupied by the pharmacy department, or a pharmacy intending to remodel or install a sterile compounding facility or equipment, shall provide written notification to the board at least 30 days prior to commencement of the remodel, pharmacy relocation, or sterile compounding installation. The board may require on-site inspection of the facility, equipment, or pharmacy department prior to or during the pharmacy's remodel, relocation, or opening. The board may also require on-site inspection of a temporary pharmacy location intended to be utilized during the remodel, construction, or relocation of the pharmacy department.

8.5(5) 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(6) Light, ventilation, temperature, and humidity. The pharmacy shall be properly lighted and ventilated. 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 and the pharmacy, by and through its owner or license holder, shall share the responsibility for ensuring 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. Established policies and procedures shall include a method to calibrate and verify the accuracy of the counting device. The pharmacy shall, at least quarterly, verify the accuracy of the device and maintain a dated record identifying the individual who performed the quarterly verification.

8.5(9) Authorized collection program. A pharmacy that is registered with the DEA to administer an authorized collection program shall provide adequate space, equipment, and supplies for such collection program pursuant to 657—Chapter 10 and federal regulations for authorized collection programs, which can be found at www.deadiversion.usdoj.gov/drug_disposal/.

8.5(10) Health of personnel. The pharmacist in charge or supervising pharmacist shall ensure that pharmacy personnel experiencing any health condition that may have an adverse effect on drug products or may pose a health or safety risk to others be prohibited from working in the pharmacy until such health condition is sufficiently resolved. All personnel who normally assist the pharmacist shall 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.

8.5(11) Hazardous drugs. The pharmacy shall ensure pharmacy personnel and patients are adequately protected from unnecessary exposure to hazardous drugs. As of December 1, 2019, the pharmacy shall be in compliance with United States Pharmacopeia (USP) General Chapter 800 for handling hazardous drugs. A pharmacy engaged in compounding of hazardous drugs may request delayed compliance for specific requirements in USP General Chapter 800 pertaining to compounding, in accordance with rule 657—20.5(126,155A).

[ARC 8671B, IAB 4/7/10, effective 5/12/10; ARC 0503C, IAB 12/12/12, effective 1/16/13; ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 2408C, IAB 2/17/16, effective 3/23/16; ARC 3858C, IAB 6/20/18, effective 7/25/18; ARC 4267C, IAB 1/30/19, effective 3/6/19; ARC 4454C, IAB 5/22/19, effective 6/26/19]

657—8.6(155A) Health of personnel. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

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 an Iowa-licensed distributor or, on a limited basis, from another licensed pharmacy or licensed practitioner located in the United States.

8.7(2) Manner of storage. Drugs and devices shall be stored in a manner to protect their identity and integrity.

8.7(3) Storage temperatures. All drugs and devices shall be stored at the proper temperature as provided in manufacturer labeling. In the absence of a specific temperature range, the pharmacy shall defer to storage conditions identified in United States Pharmacopeia chapter 659.

8.7(4) Product recall. There shall be a system for removing from use, including unit dose, any drugs and devices subjected to a product recall.

8.7(5) Outdated 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.

8.7(6) Records. All pharmacies shall maintain supplier invoices of prescription drugs and controlled substances upon which the actual date of receipt of the drugs by the pharmacist or other responsible individual is clearly recorded. All pharmacies shall maintain supplier credit memos. Pharmacy records

of invoices and credit memos shall be maintained for at least two years from the date of the record. If the original supplier invoice or credit memo is received electronically, hard-copy record is not required. [ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.8(124,155A) Out-of-date drugs or devices. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

657—8.9(124,155A) Records storage. Every 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 record or the date of last activity on the record unless a longer retention period is specified for the particular record.

8.9(1) Records less than 12 months old. Records shall be maintained within the licensed pharmacy department for a minimum of 12 months, except as provided herein. Pharmacy records less than 12 months old may be stored in a secure storage area outside the licensed pharmacy department, including at a remote location, if the pharmacy has retained electronic copies of the records in the pharmacy that are immediately available and if the original records are available within 72 hours of a request by the board or its authorized agent, unless such remote storage is prohibited under federal law.

8.9(2) Records more than 12 months old. Records more than 12 months old may be maintained in a secure storage area outside the licensed pharmacy department, including at a remote location, if the records are retrievable within 72 hours of a request by the board or its authorized agent, unless such remote storage is prohibited under federal law.

[ARC 8539B, IAB 2/24/10, effective 4/1/10; ARC 3858C, IAB 6/20/18, effective 7/25/18; ARC 5007C, IAB 3/25/20, effective 4/29/20]

657—8.10 Reserved.

657—8.11(147,155A) Unethical conduct or practice. The provisions of this rule apply to licensed pharmacies, licensed pharmacists, registered pharmacy technicians, registered pharmacy support persons, and registered pharmacist-interns.

8.11(1) Misrepresentative deeds. A pharmacy, pharmacist, technician, support person, or pharmacist-intern 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) Unethical conduct.

a. A pharmacy, pharmacist, pharmacist-intern, technician, or support person shall not participate in any of the following types of unethical conduct:

(1) Any activity that negates a patient's freedom of choice of pharmacy services.

(2) Providing prescription blanks or forms bearing the pharmacy's name or other means of identification to any person authorized to prescribe, except that a hospital may make prescription blanks or forms bearing the hospital pharmacy's name or other means of identification available to hospital staff prescribers, emergency department prescribers, and prescribers granted hospital privileges for the prescribers' use during practice at or in the hospital.

(3) Any financial arrangement or transaction that would violate federal healthcare fraud, waste, and abuse laws, including but not limited to the Stark Law, the False Claims Act, and the Anti-Kickback Statute.

b. A purchasing pharmacist or pharmacy shall not engage in any activity or include in any agreement with a selling pharmacist or pharmacy any provision that would prevent or prohibit the prior notifications required in subrule 8.35(7).

8.11(3) Discrimination. A pharmacy, pharmacist, pharmacist-intern, technician, or pharmacy support person shall not 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(4) *Unprofessional conduct or behavior.* A pharmacy, pharmacist, pharmacist-intern, technician, or pharmacy support person shall not engage in unprofessional behavior in connection with the practice of pharmacy. 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, theft, and the refusal to provide reasonable information or answer reasonable questions for the benefit of the patient.

[ARC 9526B, IAB 6/1/11, effective 7/6/11; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.12(126,147) Advertising. Prescription drug information, including price, 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 shall 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 board.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

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 child and dependent adult abuse record checks 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 request that the department of public safety perform 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 request that the department of human services perform a child and dependent adult abuse record 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.

[ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.14(155A) Training and utilization of registered pharmacy staff. Pursuant to rule 657—8.3(155A), all Iowa-licensed pharmacies utilizing pharmacist-interns, pharmacy technicians, or pharmacy support persons shall have written policies and procedures for the training and utilization of

pharmacist-interns, pharmacy technicians, and pharmacy support persons appropriate to the practice of pharmacy at that licensed location. Training shall be documented and maintained by the pharmacy for at least two years from the last date of employment or internship and shall be available for inspection by the board or its authorized agent.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.15(155A) Delivery of prescription drugs and devices. A prescription order may be delivered to a patient at any location licensed as a pharmacy. Alternatively, a pharmacy may use the mail, a common carrier, or personal delivery to deliver a prescription order to any location requested by the patient. A pharmacy that delivers prescription orders by one or more alternate methods shall have policies and procedures to ensure patient confidentiality, prescription order accountability, and proper storage of prescription orders during delivery. When counseling is required pursuant to rule 657—6.14(155A), oral counseling shall be provided before the prescription order is delivered to the patient. Documentation of the delivery of prescription orders shall be maintained by the pharmacy for at least two years from the date of delivery. The term “patient” includes the patient and the patient’s authorized representatives.

[ARC 5007C, IAB 3/25/20, effective 4/29/20]

657—8.16(124,155A) Confidential information.

8.16(1) Release of confidential information. Confidential information 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(2) Exceptions. Nothing in this rule shall prohibit a pharmacist 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 or pursuant to subrule 8.35(7) when the pharmacy is discontinuing operations.
- b. Providing the patient with a copy of a nonrefillable prescription that is clearly marked as a copy and not to be filled.
- c. Providing drug therapy information to authorized practitioners for their patients.
- d. Disclosing information necessary for the processing of third-party payer claims on behalf of the patient.

8.16(3) Record disposal. Disposal of any materials containing or including patient-specific or confidential information shall be conducted in a manner to preserve patient confidentiality.

[ARC 9526B, IAB 6/1/11, effective 7/6/11; ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.17 Reserved.

657—8.18(124,155A) Electronic prescription mandate. Beginning January 1, 2020, all prescriptions shall be transmitted electronically to a pharmacy pursuant to rule 657—21.6(124,155A), except as provided in rule 657—21.8(124,155A). A pharmacist who receives a written, oral, or facsimile prescription shall not be required to verify that the prescription is subject to an exception provided in rule 657—21.8(124,155A) and may dispense a prescription drug pursuant to an otherwise valid written, oral, or facsimile prescription pursuant to rule 657—8.19(124,126,155A).

[ARC 4580C, IAB 7/31/19, effective 9/4/19]

657—8.19(124,126,155A) Manner of issuance of a prescription drug or medication order. A prescription drug order or medication order that is issued prior to January 1, 2020, or that is exempt

from the electronic prescription mandate pursuant to rule 657—21.8(124,155A) may be transmitted from a prescriber or a prescriber's agent to a pharmacy in written form, orally including telephone voice communication, by facsimile transmission as provided in rule 657—21.7(124,155A), or by electronic transmission in accordance with applicable federal and state laws, rules, and regulations. 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—21.6(124,155A).

8.19(1) Requirements for a prescription. A valid prescription drug order shall be based on a valid patient-prescriber relationship except as provided in subrule 8.19(7) for epinephrine auto-injectors and in subrule 8.19(8) for opioid antagonists.

a. Written, electronic, or facsimile prescription. In addition to the electronic prescription application and pharmacy prescription application requirements of this rule, a written, electronic, or facsimile prescription shall include:

- (1) The date issued.
- (2) The name and address of the patient except as provided in subrule 8.19(7) for epinephrine auto-injectors, subrule 8.19(8) for opioid antagonists, or subrule 8.19(9) for expedited partner therapy.
- (3) The name, strength, and quantity of the drug or device prescribed.
- (4) The name and address of the prescriber and, if the prescription is for a controlled substance, the prescriber's DEA registration number.
- (5) The written or electronic signature of the prescriber.

b. Written prescription. In addition to the requirements of paragraph 8.19(1)“a,” a written prescription shall be manually signed, with ink or indelible pencil, by the prescriber. The requirement for manual signature shall not apply when an electronically prepared and signed prescription for a noncontrolled substance is printed on security paper as provided in 657—paragraph 21.6(2)“b.”

c. Facsimile prescription. In addition to the requirements of paragraph 8.19(1)“a,” a prescription transmitted via facsimile shall include:

- (1) The identification number of the facsimile machine used to transmit the prescription to the pharmacy.
- (2) The time and date of transmission of the prescription.
- (3) The name, address, telephone number, and facsimile number of the pharmacy to which the prescription is being transmitted.
- (4) If the prescription is for a controlled substance and in compliance with DEA regulations, the manual signature of the prescriber.

d. Electronic prescription. In addition to the requirements of paragraph 8.19(1)“a,” an electronically prepared prescription for a controlled or noncontrolled prescription drug or device that is electronically transmitted to a pharmacy shall include the prescriber's electronic signature, except as provided herein.

(1) An electronically prepared prescription for a controlled substance that is printed out or faxed by the prescriber or the prescriber's agent shall be manually signed by the prescriber.

(2) The prescriber shall ensure that the electronic prescription application used to prepare and transmit the electronic prescription complies with applicable state and federal laws, rules, and regulations regarding electronic prescriptions.

(3) The prescriber or the prescriber's agent shall provide verbal verification of an electronic prescription upon the request of the pharmacy.

(4) An electronic prescription for a noncontrolled prescription drug or device that is transmitted by an authorized agent shall not be required to contain the prescriber's electronic signature.

8.19(2) 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, rules, and regulations. In exercising professional judgment, the prescriber and the pharmacist shall take adequate measures to guard against the diversion of prescription drugs and controlled substances through prescription forgeries.

8.19(3) Transmitting agent. The prescriber may authorize an agent to transmit to the pharmacy a prescription drug order or medication order orally, by facsimile transmission, or by electronic

transmission provided that the first and last names and title of the transmitting agent are 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, except as provided in paragraph 8.19(1)“d.” If transmitted by the prescriber’s agent, the first and last names and title of the transmitting agent shall be included in the order. If the prescription is for a controlled substance and is written or printed from an electronic prescription application, the prescription shall be manually signed by the prescriber. An electronically prepared prescription shall not be electronically transmitted to the pharmacy if the prescription has been printed prior to the electronic transmission. An electronically prepared and electronically transmitted prescription that is printed following the electronic transmission shall be clearly labeled as a copy, not valid for dispensing.

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 professional pharmacy staff through oral communication, in writing, by facsimile transmission, or by electronic transmission initiated by or directed by the prescriber.

(1) If the transmission is completed by the prescriber’s agent and the first and last names and title of the transmitting agent are 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 8.19(3)“a.”

8.19(4) Receiving agent. Regardless of the means of transmission to a pharmacy, only professional pharmacy staff shall be authorized to receive a new prescription drug or medication order from a prescriber or the prescriber’s agent. A technician trainee may receive a refill or renewal order from a prescriber or the prescriber’s agent only if the technician’s supervising pharmacist has authorized that function.

8.19(5) Legitimate purpose. The pharmacy and professional pharmacy staff shall ensure that the prescription drug or medication order, regardless of the means of transmission, has been issued for a legitimate medical purpose by a prescriber acting in the usual course of the prescriber’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.

8.19(6) Refills. A refill is one or more dispensings of a prescription drug or device that result in the patient’s receipt of the quantity authorized by the prescriber for a single fill as indicated on the prescription drug order.

a. Noncontrolled prescription drug or device. 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.

b. Controlled substance. A prescription for a Schedule III, IV, or V controlled substance may authorize no more than 5 refills within 6 months following the date on which the prescription is issued.

8.19(7) Epinephrine auto-injector prescription issued to school or facility. A physician, an advanced registered nurse practitioner, or a physician assistant may issue a prescription for one or more epinephrine auto-injectors in the name of a facility as defined in Iowa Code subsection 135.185(1), a school district, or an accredited nonpublic school. The prescription shall comply with all requirements of subrule 8.19(1) as applicable to the form of the prescription except that the prescription shall be issued in the name and address of the facility, the school district, or the accredited nonpublic school in lieu of the name and address of a patient. Provisions requiring a preexisting patient-prescriber relationship shall not apply to a prescription issued pursuant to this subrule.

a. The pharmacy’s patient profile and record of dispensing of a prescription issued pursuant to this subrule shall be maintained in the name of the facility, school district, or accredited nonpublic school to which the prescription was issued and the drug was dispensed.

b. The label affixed to an epinephrine auto-injector dispensed pursuant to this subrule shall identify the name of the facility, school district, or accredited nonpublic school to which the prescription is dispensed.

8.19(8) Opioid antagonist prescription issued to law enforcement, fire department, or service program. A physician, an advanced registered nurse practitioner, or a physician assistant may issue a prescription for one or more opioid antagonists in the name of a law enforcement agency, fire department, or service program pursuant to Iowa Code section 147A.18 and rule 657—39.7(135,147A). The prescription shall comply with all requirements of subrule 8.19(1) as applicable to the form of the prescription except that the prescription shall be issued in the name and address of the law enforcement agency, fire department, or service program in lieu of the name and address of a patient. Provisions requiring a preexisting patient-prescriber relationship shall not apply to a prescription issued pursuant to this subrule.

a. The pharmacy's patient profile and record of dispensing of an opioid antagonist pursuant to this subrule shall be maintained in the name of the law enforcement agency, fire department, or service program to which the prescription was issued and the drug was dispensed.

b. The label affixed to an opioid antagonist dispensed pursuant to this subrule shall identify the name of the law enforcement agency, fire department, or service program to which the prescription is dispensed and shall be affixed such that the expiration date of the drug is not rendered illegible.

8.19(9) Expedited partner therapy. Pursuant to Iowa Code section 139A.41, a physician, physician assistant, or advanced registered nurse practitioner may issue a prescription to one or more sexual partners of an infected patient for an oral antibiotic intended to treat a sexually transmitted chlamydia or gonorrhea infection. The prescription shall comply with all requirements of subrule 8.19(1) as applicable to the form of the prescription except that the prescription shall not be required to contain the patient name and address. The prescription shall indicate the antibiotic is being issued for the purpose of expedited partner therapy. Provisions requiring a preexisting patient-prescriber relationship shall not apply to a prescription issued pursuant to this subrule.

[ARC 8171B, IAB 9/23/09, effective 10/28/09; ARC 9912B, IAB 12/14/11, effective 1/18/12; ARC 2414C, IAB 2/17/16, effective 3/23/16; ARC 2827C, IAB 11/23/16, effective 11/3/16; ARC 3858C, IAB 6/20/18, effective 7/25/18; ARC 4580C, IAB 7/31/19, effective 9/4/19; ARC 4903C, IAB 2/12/20, effective 3/18/20]

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, any remaining prescription refills may be dispensed at the discretion of the pharmacist for a suitable amount of time so that the patient can establish care with a new provider and a new order can be issued. In determining the duration of which prescriptions may be dispensed, the pharmacist shall consider the patient's health care status and access to health care services.

[ARC 3639C, IAB 2/14/18, effective 3/21/18]

657—8.21(155A) Prospective drug use review.

8.21(1) 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:

- a. Overutilization or underutilization;
- b. Therapeutic duplication;
- c. Drug-disease contraindications;
- d. Drug-drug interactions;
- e. Incorrect drug dosage or duration of drug treatment;
- f. Drug-allergy interactions;
- g. Clinical abuse/misuse;
- h. 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 pharmacy technicians or pharmacy support persons but may be delegated to registered pharmacist-interns under the direct supervision of the pharmacist.

8.21(2) A pharmacist shall be exempt from the requirements of subrule 8.21(1) when dispensing a prescription issued to an unnamed patient for an oral antibiotic pursuant to Iowa Code section 139A.41. [ARC 3858C, IAB 6/20/18, effective 7/25/18; ARC 4903C, IAB 2/12/20, effective 3/18/20]

657—8.22(155A) Notification of interchangeable biological product selection. Pursuant to Iowa Code section 155A.32, when a pharmacist substitutes a biological product that is an interchangeable biological product for the biological product prescribed, the pharmacist or pharmacist's designee shall, within five business days of dispensing the biological product, communicate to the prescriber the name and manufacturer of the biological product dispensed unless the prescription information has been entered into an electronic record system, such as an electronic medical record, electronic prescribing system, pharmacy benefit management system, or a pharmacy record to which the prescriber has access. The manner of communication to the prescriber may be via telephone, facsimile, electronic transmission, or other prevailing means.

This rule is intended to implement Iowa Code section 155A.32. [ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.23(124,155A) Individuals qualified to administer. 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. The board designates the following as qualified individuals to whom a prescriber may delegate the administration of prescription drugs.

1. Persons who have successfully completed a medication administration course.
2. Licensed pharmacists.

This rule is intended to implement Iowa Code section 155A.44. [ARC 3858C, IAB 6/20/18, effective 7/25/18]

657—8.24(155A) Documented verification. The pharmacist shall provide, document, and retain a record of 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. In an approved technician product verification program, the checking technician shall provide, document, and retain a record of the final verification for the accuracy of the patient's prescription or medication order prior to the delivery of the medication to the patient or the patient's representative.

[ARC 3858C, IAB 6/20/18, effective 7/25/18; ARC 5007C, IAB 3/25/20, effective 4/29/20]

657—8.25 Reserved.

657—8.26(155A) Continuous quality improvement program. Pursuant to rule 657—8.3(155A), each pharmacy licensed to provide pharmaceutical services to patients in Iowa shall implement or participate in a continuous quality improvement program (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 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. Pursuant to rule 657—8.3(155A), each pharmacy shall have 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 quarterly, 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 but no more than three days following discovery of the event 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.

[ARC 1961C, IAB 4/15/15, effective 5/20/15; ARC 2413C, IAB 2/17/16, effective 3/23/16; ARC 3858C, IAB 6/20/18, effective 7/25/18]

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(135,147A) Opioid antagonist dispensing by pharmacists by standing order. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

657—8.32(124,155A) Individuals qualified to administer. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

657—8.33(155A) Vaccine administration by pharmacists. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

657—8.34(155A) Collaborative drug therapy management. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

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. The current pharmacy license certificate shall be displayed in a position visible to the public. The board may issue any of the following types of pharmacy licenses: a general pharmacy license, a hospital pharmacy license, a limited use pharmacy license, or a nonresident pharmacy license. Nonresident pharmacy license applicants shall comply with board rules regarding nonresident pharmacy practice except when a waiver has been granted. Applicants for general or hospital pharmacy practice shall comply with board rules regarding general or hospital pharmacy practice except when a waiver has been granted. Any pharmacy that dispenses controlled substances to Iowa residents must also register pursuant to 657—Chapter 10.

8.35(1) Limited use pharmacy license. A limited use pharmacy license may be issued for nuclear pharmacy practice, correctional facility pharmacy practice, veterinary pharmacy practice, telepharmacy practice, and other limited use practice settings. Applications for a limited use pharmacy license shall be considered on a case-by-case basis.

8.35(2) Application. Applicants for initial licensure, license renewal, license reactivation, or license changes pursuant to subrule 8.35(6) shall complete the relevant pharmacy license application and shall include all required information and attachments. All pharmacy license applications require submission of a nonrefundable \$135 license fee plus applicable penalty fees. The application shall include the signature of the pharmacy owner's authorized representative and shall require at a minimum the following:

a. Disclosure of pharmacy ownership information, including information about the pharmacy's registered agent;

b. Identification and signature of the pharmacist in charge;

c. The identification of and average number of hours worked by all pharmacists, pharmacist-interns, pharmacy technicians, and pharmacy support persons working in the pharmacy;

d. Criminal and disciplinary history information;

e. Description of the scope of services provided by the pharmacy; and

f. If the pharmacy is located outside of Iowa, identification of a registered agent located in Iowa.

8.35(3) License renewal. A pharmacy license shall be renewed before January 1 of each year. An initial pharmacy license issued between November 1 and December 31 shall not require renewal until the following calendar year. The nonrefundable fee for a timely license renewal shall be \$135.

a. Delinquent license grace period. A pharmacy license renewal application that is postmarked or hand-delivered to the board after January 1 but prior to February 1 following expiration shall be considered delinquent and shall require the nonrefundable payment of the renewal fee plus a penalty fee of \$135. A pharmacy that submits a completed license renewal application, application fee, and penalty fee postmarked or delivered to the board office by January 31 shall not be subject to disciplinary action for continuing to operate in the month of January.

b. Delinquent license reactivation beyond grace period. If a pharmacy license is not renewed prior to the expiration of the one-month grace period identified in paragraph 8.35(3) “a,” the pharmacy may not operate or provide pharmacy services to patients in the state of Iowa until the license is reactivated. A pharmacy without a current license may apply for license reactivation by submitting an application for reactivation and a nonrefundable \$540 reactivation fee. As part of the reactivation application, the pharmacy shall disclose the prescriptions dispensed and the services, if any, that were provided to Iowa patients while the license was delinquent. A pharmacy that continues to operate or provide pharmacy services in Iowa without a current license may be subject to disciplinary sanctions.

8.35(4) Inspection of pharmacy location.

a. A new pharmacy location in Iowa shall require an on-site inspection by an authorized agent of the board. Application for a pharmacy license and other required registrations shall be submitted to the board at least 14 days prior to the anticipated inspection. Any deficiencies identified during the inspection shall be corrected and verified by an authorized agent of the board prior to the issuance of the pharmacy license. Prescription drugs, including controlled substances, may not be delivered to a new pharmacy location prior to the delivery of the pharmacy license and registration certificates.

b. A pharmacy location in Iowa which is applying for a different license type than previously held may be subject to an inspection prior to the issuance of the new license.

8.35(5) Failure to complete licensure. An application for a pharmacy license, including any other required registration applications, will become null and void if the applicant fails to complete the licensure process within six months of acceptance 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 a satisfactory inspection by an agent of the board pursuant to this rule. When an applicant fails to timely complete the licensure process, fees submitted with applications will not be transferred or refunded. If the applicant intends to proceed with a pharmacy license, a new application and fee shall be required.

8.35(6) Pharmacy license changes. When a pharmacy changes its name, location, ownership, pharmacist in charge, or license type, a completed pharmacy license application with a nonrefundable \$135 fee shall be submitted to the board pursuant to subrule 8.35(2). Upon receipt of the completed application and fee, the board shall issue an updated pharmacy license certificate, pending any necessary inspection pursuant to paragraph 8.35(4) “b,” unless the board identifies any ground for denial of the license. Any restrictions or disciplinary history associated with the previous pharmacy shall remain unchanged. A pharmacy wishing to disassociate itself from the previously licensed pharmacy restrictions or disciplinary history may petition the board for such disassociation. The burden is on the pharmacy to demonstrate that the current pharmacy is not associated with or responsible for the pharmacy as it previously existed. The old license certificate shall be returned to the board within ten days of receiving the updated license certificate.

a. Name. A change of the name under which the pharmacy is doing business shall require submission of a pharmacy license application and appropriate fee prior to the change of name.

b. Location. A change of pharmacy location shall require submission of a pharmacy license application and appropriate fee prior to the change of location. A pharmacy undergoing a change in location is required to notify patients of the change in accordance with paragraph 8.35(7) “d.” A change

of pharmacy location in Iowa may require an on-site inspection of the new location as provided in subrule 8.35(4).

c. Ownership. A change in ownership of a pharmacy shall require submission of a pharmacy license application and appropriate fee prior to the change in ownership. A change of ownership occurs when the owner listed on the pharmacy's most recent application changes or when there is a change affecting the majority ownership interest of the owner listed on the pharmacy's most recent pharmacy application. A pharmacy undergoing a change in ownership is required to notify the pharmacist in charge and patients of the change in accordance with subrule 8.35(7). A change of ownership effectively consists of closing a pharmacy and opening a new pharmacy.

d. Pharmacist in charge. In addition to the requirements of this paragraph, a change of pharmacist in charge for a nonresident pharmacy shall require registration of the new permanent pharmacist in charge if the pharmacist in charge is not currently registered by the board or licensed to practice pharmacy in Iowa.

(1) If a permanent pharmacist in charge has been identified by the time of the vacancy, a pharmacy license application identifying the new pharmacist in charge, along with the appropriate fee, shall be submitted to the board within ten days of the change.

(2) 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 shall be submitted to the board within ten days of the vacancy.

(3) If a permanent pharmacist in charge was not identified within ten days of the vacancy, the pharmacy shall, within 90 days of the vacancy, identify a permanent pharmacist in charge. A pharmacy license application identifying the permanent pharmacist in charge, along with appropriate fee, shall be submitted to the board within ten days of the appointment of a permanent pharmacist in charge. The pharmacy license application and the pharmacist in charge registration application, if needed, including appropriate fees, shall be received by the board within 90 days of the original vacancy of the permanent pharmacist in charge position.

e. License type. A change in pharmacy license type shall require submission of a pharmacy license application and appropriate fee prior to the change in license type. A pharmacy changing license type shall notify the pharmacist in charge and patients of the change in accordance with subrule 8.35(7).

f. License change application submission. An application for license change shall be timely submitted pursuant to this subrule. A licensed pharmacy that has timely submitted an application for license change and fee may continue to service Iowa patients while the license change is pending final approval. An applicant who has submitted an application for license change after the required date of submission pursuant to this subrule but within 30 days of the required date of submission shall be assessed a nonrefundable late penalty fee of \$135 in addition to the license fee. An applicant who has submitted an application for license change 31 days or later following the required date of submission pursuant to this subrule shall be assessed a nonrefundable late penalty fee of \$540.

8.35(7) Closing or sale of a pharmacy. A closing pharmacy shall ensure that all pharmacy records are transferred to another licensed pharmacy that agrees to act as custodian of the records for at least two years. A pharmacy shall not execute a sale or closing of a pharmacy unless there exists an adequate period of time prior to the pharmacy's closing for delivery of the notifications to the pharmacist in charge, the board, the DEA, and pharmacy patients as required by this subrule. The executive director may exempt a pharmacy from one or more of the notification requirements in the event of an unforeseeable closure.

a. Pharmacist in charge notification. At least 40 days prior to the effective date of the sale or closing of a pharmacy, the pharmacist in charge of the closing pharmacy shall be notified of the proposed sale or closing. Information regarding the pending sale or closure of the pharmacy may be kept confidential until public notifications, which are required 30 days prior to the pharmacy's closing, are made. The pharmacist in charge of the closing pharmacy shall provide input and direction to the pharmacy owner regarding the responsibilities of the closing pharmacy, including the notifications, deadlines, and timelines established by this subrule. The pharmacist in charge of the purchasing or

receiving pharmacy shall be notified of the pending transaction at least 30 days prior to the sale or closure of the pharmacy.

b. Board and DEA notifications. At least 30 days prior to the closing of a pharmacy, a written notice shall be sent to the board. Notification to the DEA shall be pursuant to federal regulation. Notification to the board shall include:

- (1) The anticipated date of closing or transfer of prescription drugs or records.
- (2) 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.
- (3) The name, address, DEA registration number, Iowa pharmacy license number, and CSA registration number of the location at which records will be maintained.

c. Terms of sale or purchase. If the closing is due to the sale of the pharmacy, a copy of the sale or purchase agreement, not including information regarding the monetary terms of the transaction, shall be submitted to the board upon the request of the board. The agreement shall include a written assurance from the closing pharmacy to the purchasing pharmacy that the closing pharmacy has given or will be giving notice to its patients as required by this subrule.

d. Patient notification. At least 30 days prior to closing, a closing pharmacy shall make a reasonable effort to notify all patients who had a prescription filled by the closing pharmacy within the last 18 months that the pharmacy intends to close, including the anticipated closing date.

(1) Written notification shall identify the pharmacy that will be receiving the patient's records. The notification shall advise patients that all patient records will be transferred to the identified pharmacy and that patients may contact the closing pharmacy to request the transfer of remaining refills to a pharmacy of the patient's choice. The notification shall also advise patients that after the date of closing, patients may contact the pharmacy to which the records have been transferred.

(2) Written notification shall be delivered to each patient at the patient's last address on file with the closing pharmacy by direct mail or personal delivery. A pharmacy shall not be required to provide written notice to more than one patient within the same household.

(3) Public notice shall be provided in a location and manner clearly visible to patients in the pharmacy pickup locations including drive-through prescription pickup lanes, on pharmacy or retail store entry and exit doors, and at pharmacy prescription counters.

e. Patient communication by receiving pharmacy. A pharmacy receiving the patient records of another pharmacy shall not contact the patients of the closing pharmacy until after the transfer of those patient records from the closing pharmacy to the receiving pharmacy and after the closure of the closing pharmacy.

f. Prescription drug inventory. 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 maintained in the records of the purchasing pharmacy for at least two years.

- (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 rule 657—10.19(124).
- (3) The inventory of all noncontrolled prescription drugs shall include the name, strength, dosage form, and quantity, which may be estimated.
- (4) Controlled substances and prescription drugs 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 drugs.

g. Return of certificates and forms. The pharmacy license certificate and CSA registration certificate of the closing or selling pharmacy shall be returned to the board within ten days of closing or sale. The pharmacy shall be responsible for complying with federal DEA regulations for the cancellation and return of DEA forms and certificates.

h. Signs at closed pharmacy location. 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. Nothing in this paragraph shall prohibit the display of a public notice to patients, as required in paragraph 8.35(7) “d,” for a reasonable period not to exceed six months following the pharmacy’s closing.

8.35(8) Reporting discipline and criminal convictions. A pharmacy shall, no later than 30 days after the final action, provide written notice to the board of any discipline imposed by any licensing authority on any license or registration held by the pharmacy. Discipline may include, but is not limited to, fine or civil penalty, citation or reprimand, probationary period, suspension, revocation, or voluntary surrender. A pharmacy shall, no later than 30 days after a conviction, provide written notice to the board of any criminal conviction of the pharmacy or of any pharmacy owner when that conviction is related to prescription drugs or to the operation of the pharmacy. The term criminal conviction includes instances when the judgment of conviction or sentence is deferred.

8.35(9) License verification fee. The board may require a nonrefundable fee of \$15 for completion of a request for written license verification of any pharmacy license.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 9526B, IAB 6/1/11, effective 7/6/11 (See Delay note at end of chapter); ARC 9693B, IAB 9/7/11, effective 8/11/11; ARC 0504C, IAB 12/12/12, effective 1/16/13; ARC 1962C, IAB 4/15/15, effective 5/20/15; ARC 3236C, IAB 8/2/17, effective 9/6/17; ARC 3345C, IAB 9/27/17, effective 11/1/17; ARC 3858C, IAB 6/20/18, effective 7/25/18; ARC 4268C, IAB 1/30/19, effective 3/6/19; ARC 5007C, IAB 3/25/20, effective 4/29/20]

657—8.36 to 8.39 Reserved.

657—8.40(155A,84GA,ch63) Pharmacy pilot or demonstration research projects. Rescinded ARC 3858C, IAB 6/20/18, effective 7/25/18.

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.31 through 155A.35, and 155A.41.

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CHAPTER 13
TELEPHARMACY PRACTICE

657—13.1(155A) Purpose and scope. The purpose of this chapter is to provide standards for the provision of telepharmacy services to patients. These rules provide for pharmaceutical care services at a telepharmacy site utilizing audiovisual technologies that link the telepharmacy site with a managing pharmacy and one or more verifying pharmacists. The telepharmacy site and the managing pharmacy shall be located within Iowa and shall maintain appropriate licensure by the board.

[ARC 3236C, IAB 8/2/17, effective 9/6/17]

657—13.2(155A) Definitions. For purposes of this chapter, the following definitions shall apply:

“*Board*” means the board of pharmacy.

“*CSA*” or “*CSA registration*” means a registration issued pursuant to Iowa Code section 124.303 and 657—Chapter 10.

“*DEA*” means the Drug Enforcement Administration of the U.S. Department of Justice.

“*Managing pharmacy*” means a licensed pharmacy located in Iowa that oversees the activities of one or more telepharmacy sites.

“*Telepharmacy*” means the practice of pharmacy where pharmaceutical care services are provided using audiovisual technologies linking a telepharmacy site with the managing pharmacy.

“*Telepharmacy site*” means a licensed pharmacy that is operated by a managing pharmacy and staffed by one or more telepharmacy technicians where pharmaceutical care services, including the storage and dispensing of prescription drugs, drug utilization review, and patient counseling, are provided by a licensed pharmacist through the use of technology.

“*Verifying pharmacist*” means a remote Iowa-licensed pharmacist or pharmacists who perform any step in the prescription verification and dispensing process including but not limited to: verification of data entry; product selection, packaging, and labeling; drug utilization review; and patient counseling.

[ARC 3236C, IAB 8/2/17, effective 9/6/17]

657—13.3(124,155A) Written agreement. The managing pharmacy and the telepharmacy site shall execute and maintain a current written agreement between the pharmacies. If there is no current written agreement between the pharmacies, the telepharmacy site shall immediately notify the board and shall discontinue operations as a telepharmacy site until a current written agreement between the managing pharmacy and the telepharmacy site is executed.

13.3(1) Contents of agreement. The written agreement between the managing pharmacy and a telepharmacy site shall include, but may not be limited to, the following:

a. Staffing, to include telepharmacy technician staffing, verifying pharmacist staffing and availability, and on-site pharmacist staffing as needed.

b. Hours of operation of the telepharmacy site and hours of availability of pharmacists at the managing pharmacy.

c. Emergency contact information for the managing pharmacy and the telepharmacy site.

d. A complete description of the audiovisual technology to be utilized to link the managing pharmacy and the telepharmacy site.

e. A provision that, in the event that the telepharmacy technician is not available at the telepharmacy site, that a verifying pharmacist is not available, or that the audiovisual communication connection between the telepharmacy site and the managing pharmacy is not available, the telepharmacy site shall close pending the availability of the technician, the verifying pharmacist, and the communication link or pending the arrival at the telepharmacy site of a pharmacist to provide on-site pharmacy services.

f. Activities and services to be provided by the managing pharmacy at the telepharmacy site.

g. Identification of contact persons to receive, on behalf of the managing pharmacy and the telepharmacy site, notifications and official communications regarding the written agreement. Identification of contact persons shall include delivery addresses and preferred methods of delivery of

the written communications required by this rule and any other communications affecting the written agreement between the managing pharmacy and the telepharmacy.

h. Pharmacy locations, other than the managing pharmacy, where verifying pharmacists may be based or located.

13.3(2) Termination of agreement. A managing pharmacy shall provide written notice to the board and to the telepharmacy site 90 days in advance of the managing pharmacy's intent to terminate the agreement between the telepharmacy site and the managing pharmacy. A telepharmacy site shall provide written notice to the board and to the managing pharmacy 90 days in advance of the telepharmacy site's intent to terminate the agreement between the managing pharmacy and the telepharmacy site.

a. New agreement. A new written agreement between a managing pharmacy and the telepharmacy site, including the filing of a new pharmacy license application identifying the new pharmacist in charge, shall be executed within the 90-day advance notification period.

b. No new agreement. If the telepharmacy site is unable to contract with a new managing pharmacy, the telepharmacy site shall, 30 days prior to the expiration of the 90-day advance notification period, implement the prior notification requirements for closing a telepharmacy site as provided in subrule 13.3(3). The telepharmacy site shall cease operations and close at the end of that 30-day closing notification period unless a new written agreement is executed.

13.3(3) Closing of telepharmacy site. A telepharmacy site that intends to close the telepharmacy site shall provide written notification to the managing pharmacy and the board as provided in subrule 13.3(2). In addition, the telepharmacy site shall provide written notification to the DEA and to patients and shall comply with all requirements for closing a pharmacy as provided in 657—subrule 8.35(7).

13.3(4) Closing of managing pharmacy. A managing pharmacy that intends to close the managing pharmacy shall provide written notification to the telepharmacy site and the board as provided in subrule 13.3(2). In addition, the managing pharmacy shall provide written notification to the DEA and to patients and shall comply with all requirements for closing a pharmacy as provided in 657—subrule 8.35(7). A telepharmacy site that has been managed by the closing pharmacy shall comply with the provisions of subrules 13.3(2) and 13.3(3), as applicable.

[ARC 3236C, IAB 8/2/17, effective 9/6/17]

657—13.4(155A) Responsible parties. The responsibilities identified and assigned pursuant to rule 657—8.3(155A) shall be assigned, as appropriate, to the managing pharmacy and the telepharmacy site, by and through their respective owners or license holders, to the pharmacist in charge of each respective pharmacy and to staff pharmacists, including verifying pharmacists. A telepharmacy technician shall share responsibility with the pharmacist in charge of the telepharmacy site, the telepharmacy site, and the verifying pharmacist, as assigned in rule 657—8.3(155A), for all functions assigned to and performed by the telepharmacy technician.

[ARC 3236C, IAB 8/2/17, effective 9/6/17; ARC 4798C, IAB 12/4/19, effective 1/8/20]

657—13.5 to 13.7 Reserved.

657—13.8(124,155A) General requirements for telepharmacy site. The telepharmacy site shall maintain a pharmacy license issued by the board. If the telepharmacy site plans to dispense controlled substances, the telepharmacy site shall also maintain a CSA registration and a DEA registration.

13.8(1) Located in Iowa. A telepharmacy site shall be located within the state of Iowa.

13.8(2) Pharmacist in charge. The pharmacist in charge of the managing pharmacy shall designate a pharmacist in charge of the telepharmacy site pursuant to subrule 13.9(3).

13.8(3) Security. A telepharmacy site shall employ methods to prevent unauthorized access to prescription drugs, devices, and pharmacy and patient records. Such methods may include an alarm system and shall include other security systems and methods as provided by these rules. Alarm systems and entry system locks should be disarmed when the telepharmacy site is staffed and open for business. Minimum security methods shall include:

a. Electronic keypad or other electronic entry system into the telepharmacy site or the pharmacy department that requires and records the unique identification of the individual accessing the pharmacy,

including the date and time of access. Complete access records shall be maintained for a minimum of two years beyond the date of access.

b. Secure storage such as a safe.

c. Controlled access to computer records.

d. A continuous system of video surveillance and recording of the pharmacy department that includes maintenance of recordings for a minimum of 60 days following the date of the recording.

13.8(4) Telepharmacy site signage. In addition to the patient counseling sign required pursuant to subrule 13.8(5), one or more signs, prominently posted in every prescription pick-up area and clearly visible to the public, shall inform the public that the location is a telepharmacy site supervised by a pharmacist at a remote location. Signage shall include the name, location, and telephone number of the managing pharmacy. The telepharmacy site shall also prominently post the days and times that the telepharmacy is open for business.

13.8(5) Patient counseling. Patient counseling as required by rule 657—6.14(155A) shall be provided utilizing the audiovisual technology employed between the telepharmacy site and the managing pharmacy. Every telepharmacy site shall post in every prescription pickup area, in a manner clearly visible to patients, a notice that Iowa law requires the pharmacist to discuss with the patient any new prescriptions dispensed to the patient. The board shall provide a telepharmacy site with the required signage.

13.8(6) Label requirements. In addition to the label requirements identified in 657—subrule 6.10(1), the label affixed to or on the dispensing container of any prescription drug or device dispensed by a telepharmacy site pursuant to a prescription drug order shall include, on the primary label or affixed by use of an auxiliary label, the following:

a. The name, telephone number, and address of the telepharmacy site;

b. The name and telephone number of the managing pharmacy.

13.8(7) Prohibited activities. In the physical absence of a pharmacist, the following activities are prohibited:

a. Practice of pharmacist-interns or pharmacy support persons at the telepharmacy site, except that a pharmacy support person may deliver prescriptions to patients outside the telepharmacy site but may not engage in prescription delivery or any other activities at the telepharmacy site.

b. Advising patients regarding over-the-counter products unless that advice is communicated directly by a pharmacist to the patient.

c. Dispensing or delivering prescription medications packaged by a technician into patient med paks unless an on-site pharmacist has verified the drugs in the patient med paks.

d. Technician product verification program activities.

e. Compounding, unless an on-site pharmacist has verified the accuracy and completeness of the compounded drug product.

f. All judgmental activities identified in rule 657—3.23(155A) that a pharmacy technician is prohibited from performing in the practice of pharmacy.

13.8(8) Continuous quality improvement. A telepharmacy site shall implement and participate in a continuous quality improvement program pursuant to rule 657—8.26(155A).

13.8(9) Technology failure. If the audiovisual technology between the telepharmacy site and the managing pharmacy or the verifying pharmacist is not operational, no prescriptions shall be dispensed from the telepharmacy site to a patient unless a pharmacist is physically present at the telepharmacy site.

13.8(10) Perpetual controlled substances inventory. A telepharmacy site that dispenses controlled substances shall maintain a perpetual inventory record of those controlled substances.

a. The perpetual inventory record requirement shall apply to all controlled substances maintained and dispensed by the telepharmacy site and shall not be limited only to Schedule II controlled substances.

b. The perpetual inventory record format and other requirements provided in rule 657—10.33(124,155A) shall apply to the telepharmacy site's perpetual inventory record of controlled substances, with the following exceptions:

(1) The perpetual inventory record shall contain records for all controlled substances, not just Schedule II controlled substances, and

(2) Audit of the perpetual inventory record shall be completed and the physical and perpetual inventories shall be reconciled pursuant to the requirements of 657—subrule 10.33(4) each month as part of the inspection of the telepharmacy site.

13.8(11) *Display of pharmacist license.* A telepharmacy site shall display, in a position visible to the public, the original license to practice pharmacy in Iowa of the pharmacist in charge of the telepharmacy site. The telepharmacy site shall display, in a position visible to the public, the current license renewal certificate, which may be a photocopy of an original renewal certificate, of the pharmacist in charge of the telepharmacy site and of each pharmacist who may provide patient counseling to patients at the telepharmacy site. A pharmacist working on site while the telepharmacy site is open to the public shall display an original license and current license renewal certificate pursuant to 657—subrule 8.4(1).

[ARC 3236C, IAB 8/2/17, effective 9/6/17; ARC 3862C, IAB 6/20/18, effective 7/25/18; ARC 4798C, IAB 12/4/19, effective 1/8/20; ARC 5007C, IAB 3/25/20, effective 4/29/20]

657—13.9(155A) General requirements for managing pharmacy.

13.9(1) *Distance to telepharmacy site.* The managing pharmacy shall be located in Iowa and within a 200-mile radius of a telepharmacy site to ensure that the telepharmacy site is sufficiently supported by the managing pharmacy and that necessary personnel or supplies may be delivered to the telepharmacy site within a reasonable period of time of an identified need.

13.9(2) *Emergency preparedness plan.* A managing pharmacy shall develop and include in both the managing pharmacy's and the telepharmacy site's policies and procedures a plan for continuation of pharmaceutical services provided by the telepharmacy site in case of an emergency interruption of the telepharmacy site's services. The plan shall address the timely arrival at the telepharmacy site of necessary personnel or the delivery to the telepharmacy site of necessary supplies within a reasonable period of time following the identification of an emergency need. The plan may provide for alternate methods of continuation of the services of the telepharmacy site including, but not limited to, personal delivery of patient prescription medications from an alternate pharmacy location or on-site pharmacist staffing at the telepharmacy site.

13.9(3) *Pharmacist in charge.* The pharmacist in charge of the managing pharmacy shall designate a pharmacist in charge of the telepharmacy site, who will be identified on the license of the telepharmacy site. The pharmacist in charge of the telepharmacy site shall be employed by the managing pharmacy. Nothing in this subrule shall prohibit the pharmacist in charge of the managing pharmacy from simultaneously serving as the pharmacist in charge of the telepharmacy site.

13.9(4) *Adequate audiovisual connection.* The pharmacist in charge of the managing pharmacy shall ensure adequate audiovisual connection with the telepharmacy site during all periods when the telepharmacy site is open for business including ensuring confidentiality of communications in compliance with state and federal confidentiality laws.

13.9(5) *Monthly inspection.* The pharmacist in charge of the telepharmacy site or delegate pharmacist shall be responsible for performing a monthly inspection of the telepharmacy site. Inspection reports shall be signed by the individual pharmacist who performed the inspection. Inspection records and reports shall be maintained at the telepharmacy site for two years following the date of the inspection. A copy of the inspection report shall be provided to and maintained at the managing pharmacy. The monthly inspection shall include, but may not be limited to, the following:

- a. Audit and reconciliation of controlled substances perpetual and physical inventories.
- b. Audit of electronic entry system and records.
- c. Verification that the video recording system is functioning properly and that the recordings are maintained and available for at least 60 days past the date of the recording.
- d. Compilation of a record of the number of prescriptions filled, the number of on-site pharmacist hours, and the number of hours the pharmacy site was open for business during the preceding month.
- e. Review of written policies and procedures and verification of compliance with those policies and procedures.

f. Ensuring compliance with and review of records in the continuous quality improvement program, following up with responsible personnel to address issues identified by incident reports to prevent future incidents.

g. Review of records of the receipt and disbursement of prescription drugs, including controlled substances, to ensure compliance with record-keeping requirements.

h. Inspection of drug supplies and storage areas to ensure removal and quarantine of outdated drugs.

i. Inspection of stock drug supplies and storage areas to ensure drugs are maintained in a manner to prevent diversion and maintain the integrity of the drugs, verifying that the temperatures of storage areas are appropriate for the stored drugs and equipment.

j. Inspection of pharmacy and storage areas and shelves to ensure areas and shelves are clean and free of pests and other contaminants.

13.9(6) *On-site pharmacist staffing.* In an effort to promote public health, the telepharmacy site shall be staffed by a pharmacist for at least 16 hours per month. While on site, the pharmacist shall make available to the community general health care services, which may include, but not necessarily be limited to, immunizations, medication therapy management, or health screenings, as deemed necessary and appropriate by the pharmacist in charge and as provided by policies and procedures.

a. If a pharmacist will be available at the telepharmacy site to provide in-person patient services, a consistent schedule of the pharmacist's availability shall be established and published.

b. Signage identifying the days and times when a pharmacist is on site and available to patients shall be conspicuously posted at the telepharmacy site and may be published by other means, as deemed appropriate.

c. Notice that the pharmacist will not be present at the telepharmacy site during any routinely scheduled and posted on-site availability shall be provided to the public in advance of the absence except as provided in the emergency preparedness plan.

d. If the average number of prescriptions dispensed per day by the telepharmacy site exceeds 150 prescriptions, the telepharmacy site shall provide on-site pharmacist staffing 100 percent of the time the pharmacy is open for business and shall, within ten business days, apply to the board for licensure as a general pharmacy. The average number of prescriptions dispensed per day shall be determined by averaging the number of prescriptions dispensed per day over the previous 90-day period.

[ARC 3236C, IAB 8/2/17, effective 9/6/17; ARC 4798C, IAB 12/4/19, effective 1/8/20]

657—13.10(155A) General requirements for verifying pharmacist. A verifying pharmacist shall maintain a current and active license to practice pharmacy in Iowa.

13.10(1) *Location of verifying pharmacist.* The verifying pharmacist who is performing patient counseling shall be physically located within the managing pharmacy or another pharmacy licensed to operate a pharmacy in Iowa.

13.10(2) *Adequate audiovisual connection.* The verifying pharmacist shall ensure adequate audiovisual connection with the telepharmacy site during all periods when the pharmacist is responsible for verifying telepharmacy site activities and practices, including ensuring confidentiality of communications in compliance with state and federal confidentiality laws.

13.10(3) *Verifying pharmacist training.* A verifying pharmacist shall be adequately trained on the use of the technology to ensure accurate verification and patient counseling and shall review and understand the policies and procedures of the managing pharmacy and the telepharmacy site.

13.10(4) *Patient refusal of counseling.* If a patient or patient's caregiver refuses patient counseling, the refusal shall be directly communicated by the patient or patient's caregiver to the pharmacist through audiovisual communication. A technician may not accept and communicate a refusal of patient counseling from the patient or patient's caregiver to the pharmacist.

13.10(5) *Reference library.* A verifying pharmacist shall have access to all required references applicable to the telepharmacy services provided at the telepharmacy site.

[ARC 3236C, IAB 8/2/17, effective 9/6/17]

657—13.11(155A) General requirements for telepharmacy technician. A telepharmacy technician shall maintain current national certification and registration in good standing with the board as a certified pharmacy technician.

13.11(1) Practice experience. Before practicing in a telepharmacy site, a telepharmacy technician shall have completed a minimum of 2,000 hours of practice experience as a certified pharmacy technician, at least 1,000 hours of which shall be practicing in an Iowa-licensed pharmacy and 160 hours of which shall be practicing in a managing pharmacy, at another pharmacy which uses the same audiovisual technology system, or at the telepharmacy site under the direct supervision of an onsite pharmacist.

13.11(2) Training. In addition to training required of all pharmacy technicians, a telepharmacy technician shall complete the following minimum training requirements before practicing in a telepharmacy site. Records of telepharmacy technician training shall be documented and maintained by the telepharmacy site.

- a. Review and understanding of the policies and procedures of the managing pharmacy.
- b. Review and understanding of the policies and procedures of the telepharmacy site.
- c. Review and understanding of these rules for telepharmacy practice.
- d. Review and understanding of pharmacy technician rules, 657—Chapter 3.
- e. Understanding of the operation of the audiovisual technologies to be utilized at both pharmacies.
- f. Training at the telepharmacy site under the direct supervision of an on-site verifying pharmacist. Training shall include operation and use of the audiovisual technology and other means of communication between the telepharmacy site and the managing pharmacy and all daily operations from unlocking and opening the telepharmacy site to closing and locking the telepharmacy site at the end of the business day. If the telepharmacy site is protected by one or more alarm systems, training shall include how to disarm and engage the alarm system or systems.

13.11(3) Continuing education. Beginning with the first full two-year continuing education period for renewal of the technician's national pharmacy technician certification after beginning practice as a telepharmacy technician, and for each subsequent renewal of national certification for as long as the technician continues to practice as a telepharmacy technician, the technician shall complete two hours of continuing education in each of the following activities. These continuing education requirements shall not be in addition to the total continuing education credits required to maintain national certification.

- a. Patient safety/medication errors.
- b. Pharmacy law.

13.11(4) Identification. The telepharmacy technician shall, at all times when the technician is practicing at the telepharmacy site and the telepharmacy site is open for business, wear a name badge or tag identifying the technician. The badge or tag shall include, at a minimum, the technician's first name and title. The name badge or tag shall be so designed and worn that the technician's name and title are clearly visible to the public at all times.

13.11(5) Adequate audiovisual connection. The telepharmacy technician shall ensure adequate audiovisual connection with the managing pharmacy during all periods when the telepharmacy site is open for business, including ensuring confidentiality of communications in compliance with state and federal confidentiality laws.

[ARC 3236C, IAB 8/2/17, effective 9/6/17; ARC 4798C, IAB 12/4/19, effective 1/8/20]

657—13.12 to 13.15 Reserved.

657—13.16(124,155A) Telepharmacy site—initial application.

13.16(1) License application. A telepharmacy site shall complete and submit to the board a limited use/telepharmacy license application and nonrefundable fee as provided in rule 657—8.35(155A). In addition to the application and fee, the telepharmacy site shall include the additional information identified in this rule.

13.16(2) CSA registration application. If controlled substances will be dispensed from the telepharmacy site, the telepharmacy site shall complete and submit, with the limited use/telepharmacy

license application and fee, the CSA registration application and nonrefundable fee as provided in rule 657—10.5(124).

13.16(3) *Identification of managing pharmacy.* The telepharmacy site application shall include identification of the managing pharmacy, including pharmacy name, license number, address, telephone number, and pharmacist in charge; a statement from the managing pharmacy or pharmacist in charge indicating that the managing pharmacy has executed a written agreement to provide the required services and oversight to the telepharmacy site; and a statement from the pharmacist in charge of the managing pharmacy designating the pharmacist in charge of the telepharmacy site pursuant to subrule 13.9(3).

13.16(4) *Distance to nearest pharmacy that dispenses prescription drugs to outpatients.* The telepharmacy site application shall identify the nearest currently licensed pharmacy that dispenses prescription drugs to outpatients and shall provide evidence identifying the total driving distance between the proposed telepharmacy site and the nearest currently licensed pharmacy that dispenses prescription drugs to outpatients.

a. If the distance between the proposed telepharmacy site and the nearest currently licensed pharmacy that dispenses prescription drugs to outpatients is less than ten miles, the telepharmacy site shall submit a request for waiver of the distance requirement. The process and requirements for a request for waiver are identified in subrule 13.16(8).

b. The distance requirement shall not apply under any of the following circumstances:

(1) The telepharmacy site was approved by the board and operating as a telepharmacy site prior to July 1, 2016.

(2) The proposed telepharmacy site is located within a hospital campus, and services will be limited to inpatient dispensing.

(3) The proposed telepharmacy site is located on property owned, operated, or leased by the state.

13.16(5) *Written agreement.* The telepharmacy site application shall include the written agreement between the telepharmacy site and the managing pharmacy as described in subrule 13.3(1).

13.16(6) *Key personnel.* The telepharmacy site application shall identify key personnel including the pharmacist in charge of the managing pharmacy, the pharmacist in charge of the telepharmacy site, and the telepharmacy technician or technicians at the telepharmacy site. Identification shall include the names, the license or registration numbers, and the titles of the key personnel. Telepharmacy technician identification shall also include a copy of the telepharmacy technician's current national certification or other verification of the telepharmacy technician's current national certification.

13.16(7) *Audiovisual technology.* A description of the audiovisual technology system to be used to link the managing pharmacy and the telepharmacy site, including built-in safeguards relating to verification of the accuracy of the dispensing processes. Safeguards shall include but may not be limited to:

a. Requiring a verifying pharmacist to review and compare the electronic image of any new prescription with the data entry record of the prescription prior to authorizing the telepharmacy site's system to print a prescription label and prior to the telepharmacy technician's filling of the prescription at the telepharmacy site.

b. Requiring the technician to use barcode technology at the telepharmacy site to verify the accuracy of the drug to be dispensed.

c. Requiring remote visual confirmation by a verifying pharmacist of the drug stock bottle and the drug to be dispensed prior to the dispensing of the prescription at the telepharmacy site.

d. Ensuring that the telepharmacy site's system prevents a prescription from being sold and delivered to a patient before the verifying pharmacist has performed a final verification of the accuracy of the prescription and released the prescription for sale and delivery at the telepharmacy site.

13.16(8) *Request for distance waiver.* The board shall consider a request for waiver of the distance requirement between the proposed telepharmacy site and the nearest currently licensed pharmacy that dispenses prescription drugs to outpatients if the petitioner can demonstrate to the board that the proposed telepharmacy site is located in an area where there is limited access to pharmacy services and that there exist compelling circumstances that justify waiving the distance requirement.

a. The request for waiver shall be prepared and shall include the elements of a request for waiver or variance identified in 657—Chapter 34.

b. In addition to the requirements of 657—Chapter 34, the request for waiver shall include evidence and specific information regarding each of the following, if applicable. If an item identified below does not apply to the proposed telepharmacy site, the request for waiver shall specifically state that the item does not apply.

(1) That the nearest currently licensed pharmacy that dispenses prescription drugs to outpatients is open for business for limited hours or fewer hours than the proposed telepharmacy site.

(2) That the proposed telepharmacy site intends to provide services not available from the nearest currently licensed pharmacy that dispenses prescription drugs to outpatients.

(3) That access to the nearest currently licensed pharmacy that dispenses prescription drugs to outpatients is limited. A description of how the proposed telepharmacy site will improve patient access to pharmacy services shall be included.

(4) That limited access to pharmacy services is affecting patient safety.

(5) That there are transportation barriers to services from the nearest currently licensed pharmacy that dispenses prescription drugs to outpatients.

(6) That the nearest currently licensed pharmacy that dispenses prescription drugs to outpatients is closing.

(7) That the proposed telepharmacy site is located in an area of the state where there is limited access to pharmacy services.

c. The board shall consider a request for waiver of the distance requirement during any open session of a meeting of the board. One or more representatives of the parties to the waiver request, including representatives of the proposed telepharmacy site, the managing pharmacy, and the nearest currently licensed pharmacy that dispenses prescription drugs to outpatients, shall be invited and encouraged to attend the meeting at which the waiver request is scheduled for consideration to be available to respond to any questions.

d. The board's decision to grant or deny the request for waiver of the distance requirement shall be a proposed decision and shall be reviewed by the director of the department of public health.

(1) The director shall have the power to approve, modify, or veto the board's proposed decision regarding the waiver request.

(2) The director's decision on a waiver request shall be considered final agency action.

(3) The director's decision (final agency action) shall be subject to judicial review under Iowa Code chapter 17A.

[ARC 3236C, IAB 8/2/17, effective 9/6/17; ARC 4268C, IAB 1/30/19, effective 3/6/19; ARC 4798C, IAB 12/4/19, effective 1/8/20]

657—13.17(124,155A) Changes to telepharmacy site or managing pharmacy. Except as specifically provided by these rules, a change to a telepharmacy site shall require compliance with the licensure and notification requirements of the specific type of change identified in 657—subrules 8.35(6) and 8.35(7). A change affecting the CSA registration shall comply with the appropriate requirements of rule 657—10.9(124).

13.17(1) Change of pharmacist in charge. A change of pharmacist in charge at either the managing pharmacy or telepharmacy site shall require submission of a pharmacy license application for the respective pharmacy location as provided by 657—subrule 8.35(6) and rule 657—13.16(124,155A).

13.17(2) Closing or selling of pharmacy. A telepharmacy site or managing pharmacy that intends to close or sell the pharmacy practice shall comply with all requirements for closing or selling a pharmacy found at 657—subrules 8.35(6) and 8.35(7) regarding ownership change and closing a pharmacy, including all advance notification requirements. A purchaser of a telepharmacy site shall complete and submit applications and supporting information as provided in rule 657—13.16(124,155A). A closing pharmacy shall also comply with the requirements of subrule 13.3(3) or 13.3(4), as appropriate.

13.17(3) Location change. A telepharmacy site that intends to move to and to provide telepharmacy services from a new location that is outside the community wherein the telepharmacy site has been located shall comply with the requirements of subrule 13.17(2) for closing a pharmacy and shall submit

applications and supporting information as provided in rule 657—13.16(124,155A). A managing pharmacy that intends to move to a new location shall comply with the requirements of 657—subrules 8.35(4), 8.35(6), and 8.35(7), as appropriate.

[ARC 3236C, IAB 8/2/17, effective 9/6/17; ARC 3858C, IAB 6/20/18, effective 7/25/18; ARC 4798C, IAB 12/4/19, effective 1/8/20]

657—13.18(155A) Opening of traditional pharmacy. If a pharmacy licensed as a general, hospital, or limited use pharmacy opens for business within ten miles of an existing and operating telepharmacy site, the telepharmacy site may continue to operate as a telepharmacy site and shall not be required to close due to the proximity of the new pharmacy.

[ARC 3236C, IAB 8/2/17, effective 9/6/17]

657—13.19 and 13.20 Reserved.

657—13.21(124,155A) Policies and procedures. In addition to policies and procedures required for the specific services provided and identified in other chapters of board rules, both the managing pharmacy and the telepharmacy site shall develop, implement, and adhere to written policies and procedures for the operation and management of the specific pharmacy's operations.

13.21(1) Minimum requirements. Policies and procedures shall define the frequency of review, and written documentation of review by the respective pharmacist in charge shall be maintained. Policies and procedures shall address, at a minimum, the following:

a. Procedures ensuring that a record is made and retained identifying the pharmacist who verified the accuracy of the prescription including the accuracy of the data entry, the selection of the correct drug, the accuracy of the label affixed to the prescription container, and the appropriateness of the prescription container.

b. Procedures ensuring that a record is made and retained identifying the pharmacist who performed the drug utilization review as provided by rule 657—8.21(155A).

c. Procedures ensuring that a record is made and retained identifying the pharmacist who provided counseling to the patient or the patient's caregiver pursuant to rule 657—6.14(155A).

d. Procedures ensuring that a record is made and retained identifying the technician who filled the prescription.

e. Procedures ensuring adequate security to prevent unauthorized access to prescription drugs and devices and to confidential records.

f. Procedures regarding procurement of drugs and devices, including who is authorized to order or receive drugs and devices, from whom drugs and devices may be ordered and received, and the required method for documentation of the receipt of drugs and devices.

g. Procedures ensuring appropriate and safe storage of drugs at the telepharmacy site, including appropriate temperature controls.

h. Procedures identifying the elements of a monthly inspection of the telepharmacy site by the pharmacist in charge or designated pharmacist, including requirements for documentation and retention of the results of each inspection.

i. Procedures for the temporary quarantine of out-of-date and adulterated drugs from dispensing stock and the subsequent documented disposal of those drugs.

j. Procedures and documentation required in the case of return to the telepharmacy of a drug or device.

k. Procedures for drug and device recalls.

13.21(2) Availability. Policies and procedures shall be available for inspection and copying by the board or the board's representative at the location to which the policies and procedures apply.

[ARC 3236C, IAB 8/2/17, effective 9/6/17; ARC 4798C, IAB 12/4/19, effective 1/8/20]

657—13.22(155A) Reports to the board. The board may periodically request information regarding the services provided by a telepharmacy site.

13.22(1) Timeliness. A telepharmacy site shall complete and submit the requested information in a timely manner as requested by the board. The board shall allow a reasonable amount of time for a telepharmacy site to complete and submit the requested information.

13.22(2) Information to include. Information requested may include, but may not necessarily be limited to, the following:

- a. The number of prescriptions dispensed from the telepharmacy site over a specified period of time.
- b. The number of hours a pharmacist was physically present at the telepharmacy site over a specified period of time.
- c. The number of hours the telepharmacy site was open for business over a specified period of time.

[ARC 3236C, IAB 8/2/17, effective 9/6/17]

657—13.23(124,155A) Records. Every inventory or other record required to be kept under Iowa Code chapters 124 and 155A or rules of the board shall be kept by the telepharmacy site and be available for inspection and copying by the board or its representative for at least two years from the date of the inventory or record except as specifically identified by law or rule. Controlled substances records shall be maintained in a readily retrievable manner in accordance with federal requirements and 657—Chapter 10.

13.23(1) Dispensing record. As provided in rule 657—13.21(124,155A), a written or electronic record identifying the pharmacist who verified the prescription, the pharmacist who provided counseling to the patient or the patient's caregiver, and the pharmacy technician who filled the prescription shall be maintained for every prescription fill dispensed by the telepharmacy site.

13.23(2) On-site pharmacist staffing. A written or electronic record of the number of prescriptions filled, the number of on-site pharmacist hours, and the number of hours the telepharmacy site was open for business each month shall be maintained by the telepharmacy site.

13.23(3) Pharmacy access. Records identifying, by unique identification of the individual accessing the pharmacy department, including the date and time of access, shall be maintained for two years beyond the date of access.

13.23(4) Monthly inspection. Reports of the monthly inspection of the telepharmacy site shall be maintained at the telepharmacy site for two years following the date of the inspection. A copy of the inspection report shall be provided to and maintained at the managing pharmacy for two years following the date of the inspection.

[ARC 3236C, IAB 8/2/17, effective 9/6/17]

These rules are intended to implement Iowa Code sections 124.301, 147.107, 155A.3, 155A.6A, 155A.13, 155A.14, 155A.19, 155A.28, 155A.31, 155A.33, and 155A.41.

[Filed ARC 3236C (Notice ARC 3037C, IAB 4/26/17), IAB 8/2/17, effective 9/6/17]

[Filed ARC 3858C (Notice ARC 3509C, IAB 12/20/17), IAB 6/20/18, effective 7/25/18]

[Filed ARC 3862C (Notice ARC 3508C, IAB 12/20/17), IAB 6/20/18, effective 7/25/18]

[Filed ARC 4268C (Notice ARC 4092C, IAB 10/24/18), IAB 1/30/19, effective 3/6/19]

[Filed ARC 4798C (Notice ARC 4593C, IAB 8/14/19), IAB 12/4/19, effective 1/8/20]

[Filed ARC 5007C (Notice ARC 4695C, IAB 10/9/19), IAB 3/25/20, effective 4/29/20]

CHAPTER 17
WHOLESALE DISTRIBUTOR LICENSES

657—17.1(155A) Purpose and scope. This chapter establishes the licensing requirements and standards applicable to a wholesale distributor of human prescription drugs as defined by Iowa Code section 155A.3 and the Drug Supply Chain Security Act. In the event the requirements in this chapter directly conflict with any federal law or regulation, the federal law or regulation shall supersede the requirements in this chapter.

[ARC 4190C, IAB 12/19/18, effective 1/23/19; ARC 5008C, IAB 3/25/20, effective 4/29/20]

657—17.2(155A) Definitions. In addition to the definitions found in Iowa Code section 155A.3, which are adopted for the purposes of this chapter, the following definitions shall apply:

“*Drug Supply Chain Security Act*” or “*DSCSA*” means the law enacted by Congress in November 2013 which establishes the minimum standards for ensuring a legitimate drug supply chain.

“*Facility manager*” means the individual responsible for managing the daily operations of the wholesale distribution facility.

“*FDA*” means the United States Food and Drug Administration.

“*Returns processor*” means a person who owns or operates an establishment that dispositions or otherwise processes saleable or nonsaleable product received from a purchaser, manufacturer, or seller who purchased or received such product at wholesale, such that the product may be processed for credit to the purchaser, manufacturer, or seller, or disposed of for no further distribution.

“*Wholesale distribution*” means the distribution of a drug to a person other than a consumer or patient, or the receipt of a drug by a person other than a consumer or patient, but does not include transactions identified in Iowa Code section 155A.3 and DSCSA.

“*Wholesale distributor*” means a person, other than a manufacturer, a manufacturer’s co-licensed partner, a third-party logistics provider, or a repackager, engaged in the wholesale distribution of a prescription drug.

[ARC 4190C, IAB 12/19/18, effective 1/23/19; ARC 5008C, IAB 3/25/20, effective 4/29/20]

657—17.3(155A) Wholesale distributor license. Every wholesale distributor that engages in wholesale distribution into, out of, or within this state must be licensed by the board before engaging in wholesale distribution. Where operations are conducted at more than one location by a single wholesale distributor, each such location shall be separately licensed. The applicant shall submit a completed application with a nonrefundable application fee of \$750. A wholesale distributor that engages in wholesale distribution of controlled substances into, out of, or within this state shall also obtain a controlled substances Act registration pursuant to 657—Chapter 10.

17.3(1) Application. The applicant shall complete an application which requires demographic information about the wholesale distributor, ownership information, information about the wholesale distributor’s registered agent located in Iowa, information about the wholesale distributor’s licensure with other state and federal regulatory authorities, criminal and disciplinary history information, information regarding the facility manager, a detailed description of the services to be provided in this state, and other necessary information as determined by the board. An application for a wholesale distributor 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, including opening for business, within six months of receipt by the board of the required application(s). The following shall also be submitted by the applicant for the application to be considered complete:

a. Criminal history record check. Upon receipt of a licensure application, the board shall provide a fingerprint packet to the applicant’s facility manager, who shall submit the completed fingerprint packet and a signed waiver form to facilitate a national criminal history background check of the facility manager. The cost of the evaluation of the fingerprint packet and the Iowa division of criminal investigation and the United States Federal Bureau of Investigation criminal history background checks will be assessed to the applicant.

b. Surety bond or equivalent security. The applicant shall file with the board a \$100,000 surety bond or evidence that the wholesale distributor possesses the required bond in another state where the wholesale distribution facility does business. If a wholesale distributor's annual gross receipts from the previous tax year were \$10 million or less, the wholesale distributor need only file a \$25,000 surety bond. In lieu of a surety bond, the applicant may submit an irrevocable standby letter of credit in the amount of \$100,000 or \$25,000 as applicable. A government-owned wholesale distributor is exempt from the surety bond requirement.

c. Evidence of current verified-accredited wholesale distributors (VAWD) accreditation by the National Association of Boards of Pharmacy. This requirement does not apply to new applicants located in Iowa which must undergo an opening inspection by a board compliance officer or agent of the board prior to issuance of an initial license. Wholesale distributors located in Iowa shall provide evidence of VAWD accreditation on or before license renewal.

d. Attestation by facility manager. The applicant shall submit attestation that the facility manager has been employed full-time for at least three years in a position related to prescription drug distribution; is actively involved in the daily operation of the wholesale distribution facility; maintains a functional understanding of federal and state laws, rules, and regulations pertaining to wholesale drug distribution; and has no felony convictions or convictions related to prescription drug distribution, including distribution of controlled substances.

17.3(2) License renewal. A wholesale drug license shall be renewed before January 1 of each year and may be renewed as early as November 1 prior to expiration. The wholesale distributor shall submit a completed application and nonrefundable application fee as required in this rule.

a. *Delinquent license grace period.* If a wholesale drug license has not been renewed or canceled prior to expiration, the license becomes delinquent on January 1. A wholesale distributor that submits a completed license renewal application, nonrefundable application fee, and nonrefundable late penalty fee of \$750 postmarked or delivered to the board by January 31 shall not be subject to disciplinary action for continuing to provide services in this state in the month of January.

b. *Delinquent license reactivation beyond grace period.* If a wholesale drug license has not been renewed prior to the expiration of the one-month grace period identified in paragraph 17.3(2) "a," the wholesale distributor may not operate or do business in Iowa. A wholesale distributor that continues to do business in Iowa without a current license may be subject to disciplinary sanctions pursuant to the provisions of 657—subrule 36.6(22). A wholesale distributor without a current license may apply for reactivation by submitting a license application for reactivation and a nonrefundable \$2,000 reactivation fee. As part of the reactivation application, the wholesale distributor shall disclose the services, if any, that were provided in this state while the license was delinquent.

17.3(3) License changes. When a licensed wholesale distributor changes its name, ownership, facility manager, or location, a wholesale drug license application with a nonrefundable application fee as provided in subrule 17.3(1) shall be submitted to the board. A change of ownership occurs when the owner listed on the wholesale distributor's most recent application changes or when there is a change affecting the majority ownership interest of the owner listed on the wholesale distributor's most recent application. A change of wholesale distributor location within Iowa, if the new location was not a licensed wholesale distributor immediately prior to the relocation, shall require an on-site inspection of the new location as provided in paragraph 17.3(1) "c."

a. *Locations in Iowa.* Applications for license changes shall be submitted to the board as far in advance as possible prior to the anticipated change.

b. *Locations outside of Iowa.* Applications for license changes shall be submitted to the board within ten days of the wholesale distributor's receipt of an updated license from the home state regulatory authority.

c. *License change application submission.* Applications for license changes shall be timely submitted pursuant to this subrule. A licensed wholesale distributor that has timely submitted a license change application and fee may continue to service Iowa customers while the license change is pending final approval. An applicant that has submitted an application for license changes after the required date of submission pursuant to this subrule but within 30 days of the required date of submission shall be

assessed a nonrefundable late penalty fee of \$750 in addition to the license fee. An applicant that has submitted an application for license changes 31 days or later following the required date of submission pursuant to this subrule shall be assessed a nonrefundable reactivation fee of \$2,000.

d. Change in facility manager. When a wholesale distributor has a change in facility manager, a new facility manager shall be identified pursuant to this paragraph. If a permanent facility manager is not currently the facility manager of a licensed facility, the facility manager shall submit to a criminal background check.

(1) If a permanent facility manager has been identified at the time of the vacancy, a wholesale distributor license application identifying the new permanent facility manager, along with the appropriate fee, shall be submitted to the board within ten days of the vacancy.

(2) If no permanent facility manager has been identified at the time of the vacancy, a temporary facility manager shall be identified and notice of such shall be submitted in writing to the board within ten days of the vacancy. A temporary facility manager shall not be required to submit a fingerprint packet and signed waiver to facilitate a national criminal history check unless the temporary facility manager subsequently is identified as the permanent facility manager. Within 90 days of the vacancy, a permanent facility manager shall be identified and a wholesale distributor license application identifying the permanent facility manager, along with the appropriate fee, shall be submitted to the board.

17.3(4) License cancellation. A licensee intending to discontinue wholesale distribution into, out of, or within this state shall notify the board in writing of its intent as far in advance as possible of the discontinuation of services and shall request that the license be administratively canceled. Such notification shall include the name and license number of the wholesale distributor, the anticipated date of discontinuation of service, and the identification of the wholesale distributor to which drugs and records will be transferred. To the extent possible to avoid unnecessary delays in obtaining product for patients, a wholesale distributor that intends to discontinue services in this state should provide advance notice to its customers of the date that the wholesale distributor intends to cease distribution in this state.

[ARC 4190C, IAB 12/19/18, effective 1/23/19; ARC 5008C, IAB 3/25/20, effective 4/29/20]

657—17.4(155A) Grounds for denial. The board may deny a wholesale distributor license application, or refuse to renew a wholesale distributor license, for any of the following:

1. Any criminal convictions of the applicant or facility manager related to wholesale distribution;
2. Any felony convictions of the applicant;
3. Insufficient experience in the wholesale distribution business, including a lack of knowledge regarding the requirements of applicable federal and state laws or regulations;
4. The furnishing of false or fraudulent material;
5. Suspension, revocation, or other disciplinary action taken by the licensing authority of another state or federal agency against any license or registration currently or previously held by the applicant;
6. Noncompliance with licensing requirements under previously granted licenses, if any;
7. Noncompliance with the requirements to maintain or make available to the board, its agents, or to federal, state, or local law enforcement officials those records required to be maintained by wholesale distributors;
8. Conducting transactions with a person that is not properly licensed or registered; and
9. Any other factors or qualifications the board considers relevant to and consistent with public health and safety.

[ARC 4190C, IAB 12/19/18, effective 1/23/19]

657—17.5 and 17.6 Reserved.

657—17.7(124,155A) Compliance with federal and state laws. A wholesale distributor is responsible for complying with all applicable federal and state laws, including those not specifically identified in this chapter.

17.7(1) A licensed wholesale distributor shall meet the requirements set forth in the Drug Supply Chain Security Act, including but not limited to:

- a. 21 U.S.C. §360eee-1, relating to product tracing, product identifiers, authorized trading partners, suspect products, and illegitimate products;
- b. 21 U.S.C. §360eee-2, relating to national standards for drug wholesale distributors; and
- c. Any regulations promulgated thereunder.

17.7(2) A licensed wholesale distributor shall permit agents of the board to enter and inspect the facility for compliance with federal and state laws. A licensed wholesale distributor shall cooperate with other regulatory or law enforcement officials with jurisdiction over the facility.
[ARC 4190C, IAB 12/19/18, effective 1/23/19]

657—17.8(124,155A) Written policies and procedures. Wholesale distributors shall establish, maintain, and adhere to written policies and procedures that are in compliance with federal law for the receipt, security, storage, inventory, and distribution of prescription drugs, including policies and procedures for identifying, recording, and reporting losses or thefts and for correcting all errors and inaccuracies in inventories. Wholesale distributors shall also include in their written policies and procedures the following:

17.8(1) Recalls and market withdrawals. A procedure to be followed for handling recalls and withdrawals of prescription drugs.

- a. The procedure shall be adequate to deal with recalls and withdrawals due to:
 - (1) Any action initiated at the request of the Food and Drug Administration or other federal, state, or local law enforcement agency or other government agency, including the board;
 - (2) Any voluntary action by the manufacturer to remove defective or potentially defective drugs from the market; or
 - (3) Any action undertaken to promote public health and safety by replacing existing merchandise with an improved product or new package design.

b. The requirement of this subrule shall not apply to a returns processor.

17.8(2) Emergency and disaster plan. A procedure to ensure that wholesale distributors prepare for, protect against, and handle any crisis that affects security or operation of any facility in the event of strike, fire, flood, or other natural disaster, or other situations of local, state, or national emergency.

17.8(3) Outdated drugs. A procedure to ensure that any outdated prescription drugs shall be segregated from other drugs and either returned to the manufacturer or destroyed. This procedure shall provide for written documentation of the disposition of outdated prescription drugs. The requirement of this subrule shall not apply to a returns processor.

17.8(4) Security and storage. A procedure to ensure adequate security in accordance with rule 657—17.10(124,155A) and proper storage conditions in accordance with rule 657—17.11(155A). The requirement for proper storage conditions shall not apply to a returns processor.

17.8(5) Drugs supplied to salesperson/representative. If supplying drugs to wholesale distributor salespersons, a procedure directing that the security, storage, and record-keeping requirements contained in these rules shall be maintained by those salespersons.

17.8(6) Personnel. A procedure to ensure the wholesale distributor employs personnel with the education and experience appropriate to the responsibilities of the position held by the individual. Licensed wholesale distributors shall establish and maintain lists of officers, directors, managers, and other persons in charge of wholesale drug distribution, storage, and handling, including a description of their duties and a summary of their qualifications.

[ARC 4190C, IAB 12/19/18, effective 1/23/19]

657—17.9(155A) Facilities. All wholesale distribution facilities shall:

1. Be of suitable size and construction to facilitate cleaning, maintenance, and proper operations;
2. Have storage areas designed to provide adequate lighting, ventilation, temperature, sanitation, humidity, space, equipment, and security conditions;
3. Except for returns processors, have a quarantine area for storage of outdated, damaged, unsafe, deteriorated, misbranded, or adulterated prescription drugs; for drugs that are in immediate or sealed outer or sealed secondary containers that have been opened; for drugs that have been identified as being

defective or are believed to be defective; and for drugs that do not meet the FDA-approved criteria for the product;

4. Be maintained in a clean and orderly condition;
5. Be free from infestation by insects, rodents, birds, or vermin of any kind.

[ARC 4190C, IAB 12/19/18, effective 1/23/19]

657—17.10(124,155A) Security.

17.10(1) *Secure from unauthorized entry.* All wholesale distribution facilities shall be secure from unauthorized entry.

- a. Access from outside the premises shall be kept to a minimum and be well controlled.
- b. The outside perimeter of the premises shall be well lighted.
- c. Entry into areas where prescription drugs are held shall be limited to authorized personnel.

17.10(2) *Alarm.* All wholesale distribution facilities shall be equipped with an alarm system to deter entry after hours.

17.10(3) *Security system.* All wholesale distribution facilities shall be equipped with a security system that will provide suitable protection against theft and diversion. When appropriate, the security system shall provide protection against theft or diversion that is facilitated or hidden by tampering with computers or electronic records.

[ARC 4190C, IAB 12/19/18, effective 1/23/19]

657—17.11(155A) Storage and handling. All prescription drugs shall be stored and shipped at appropriate temperatures and under appropriate conditions in accordance with requirements, if any, in the labeling of such drugs or with requirements in the current edition of the United States Pharmacopeia. Manual, electromechanical, or electronic temperature and humidity monitoring and recording equipment, devices, or logs shall be utilized to document proper storage of prescription drugs to prevent and detect excursions. Shipment of prescription drugs requiring refrigeration shall maintain temperature requirements in accordance with the manufacturer requirements or as described in the current edition of the United States Pharmacopeia. All excursions shall be evaluated to determine any adverse impact on the integrity of the drug. The requirements of this rule do not apply to nonsaleable returns handled by returns processors.

[ARC 4190C, IAB 12/19/18, effective 1/23/19]

657—17.12 to 17.16 Reserved.

657—17.17(155A) Reporting discipline and criminal convictions. No later than 30 days after the final action, a wholesale distributor shall provide to the board written notice, including an unredacted copy of the action or order, of any disciplinary or enforcement action imposed by any licensing or regulatory authority on any license or registration held by the wholesale distributor. Discipline may include, but is not limited to, fine or civil penalty, citation or reprimand, probationary period, suspension, revocation, and voluntary surrender. No later than 30 days after conviction, a wholesale distributor shall provide to the board written notice, including an unredacted copy of the judgment of conviction or sentence, of any criminal conviction of the wholesale distributor, any owner of the wholesale distributor, or facility manager, if the conviction is related to prescription drug distribution. The term “criminal conviction” includes instances when the judgment of conviction or sentence is deferred.

[ARC 4190C, IAB 12/19/18, effective 1/23/19]

657—17.18(155A) Discipline. Pursuant to 657—Chapter 36, the board may fine, suspend, revoke, or impose other disciplinary sanctions on a wholesale distributor license for any of the following:

1. Any violation of the federal Food, Drug, and Cosmetic Act or federal regulation promulgated under the Act.
2. Any conviction of a crime related to the distribution of prescription drugs committed by the wholesale distributor, its owners, or the facility manager.
3. Refusing access to the wholesale distribution facility or records to an agent of the board for the purpose of conducting an inspection or investigation.

4. Failure to maintain registration pursuant to 657—Chapter 10 when distributing controlled substances into, out of, or within this state.

5. Any act of unethical or unprofessional conduct by an employee of the wholesale distributor.

6. Any violation of Iowa Code chapter 124, 126, 155A, or 205, or rule of the board, including the disciplinary grounds set forth in 657—Chapter 36.

[ARC 4190C, IAB 12/19/18, effective 1/23/19]

These rules are intended to implement Iowa Code sections 124.301 through 124.308, 126.3, 126.9 through 126.12, 155A.3, 155A.4, 155A.17, 155A.19, 155A.21, 155A.23, and 155A.40 and the federal Drug Supply Chain Security Act.

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CHAPTER 21
ELECTRONIC DATA AND AUTOMATED SYSTEMS IN PHARMACY PRACTICE

657—21.1(124,155A) Purpose and scope. The purpose of this chapter is to provide the minimum standards for the utilization of electronic data and automated systems in the practice of pharmacy and shall apply to all pharmacies located in Iowa.

[ARC 3640C, IAB 2/14/18, effective 3/21/18]

657—21.2(124,155A) Definitions. For the purpose of this chapter, the following definitions shall apply:

“Automated data processing system” means an application that is used for prescription, patient, drug, and prescriber information; installed on a pharmacy’s computer or server; and controlled by the pharmacy.

“Automated medication distribution system” or *“AMDS”* includes, but is not limited to, an automated device or series of devices operated by an electronic interface with one or more computers that is used to prepare, package, or dispense specified dosage units of drugs for administration or dispensing. *“AMDS”* does not include electronic storage devices that do not have an electronic interface with one or more computers of the pharmacy.

“CSA” means the Iowa uniform controlled substances Act.

“CSA registration” means the registration issued by the board pursuant to the CSA that signifies the registrant’s authorization to engage in registered activities with controlled substances.

“DEA” means the U.S. Department of Justice, Drug Enforcement Administration.

“Electronically prepared prescription” means a prescription that is generated utilizing an electronic prescription application.

“Electronic device” means an electronic, mechanical, or other device which is used to intercept communications and includes but is not limited to network, file and print servers; desktop workstations; laptop computers; tablets; mini-computers; smart phones; and similar devices.

“Electronic prescription” means an electronically prepared prescription that is authorized and transmitted from the prescriber to the pharmacy by means of electronic transmission.

“Electronic prescription application” means software that is used to create electronic prescriptions and that is intended to be installed on a prescriber’s computers and servers where access and records are controlled by the prescriber.

“Electronic signature” means a confidential personalized digital key, code, number, or other method used for secure electronic data transmissions which identifies a particular person as the source of the message, authenticates the signatory of the message, and indicates the person’s approval of the information contained in the transmission.

“Electronic transmission” means the transmission of an electronic prescription, formatted as an electronic data file, from a prescriber’s electronic prescription application to a pharmacy’s computer, where the data file is imported into the pharmacy prescription application.

“Facsimile transmission” or *“fax transmission”* means the transmission of a digital image of a prescription from the prescriber or the prescriber’s agent to the pharmacy. *“Facsimile transmission”* includes but is not limited to transmission of a written prescription between the prescriber’s fax machine and the pharmacy’s fax machine; transmission of an electronically prepared prescription from the prescriber’s electronic prescription application to the pharmacy’s fax machine or printer; or transmission of an electronically prepared prescription from the prescriber’s fax machine to the pharmacy’s fax machine, computer, or printer.

“Intermediary” means any technology system that receives and transmits an electronic prescription between the prescriber and the pharmacy.

“Pharmacist verification” or *“verified by a pharmacist”* means the accuracy of a prescription drug is verified by a pharmacist, pharmacist-intern, or technician in an approved technician product verification program.

“*Prescription drug order*” or “*prescription*” means a lawful order of a practitioner for a drug or device for a specific patient that is communicated to a pharmacy, regardless of whether the communication is oral, electronic, via facsimile, or in printed form.

“*Readily retrievable*” means that hard-copy or electronic records can be separated out from all other records within 72 hours of a request from the board or other authorized agent.

“*Written prescription*” means a prescription that is created on paper, a prescription that is electronically prepared and printed, or a prescription that is electronically prepared and transmitted from the prescriber’s electronic device to a pharmacy via facsimile. A written prescription for a controlled substance shall be manually signed by the prescriber in compliance with federal and state laws, rules, and regulations.

[ARC 3640C, IAB 2/14/18, effective 3/21/18; ARC 4580C, IAB 7/31/19, effective 9/4/19; ARC 5007C, IAB 3/25/20, effective 4/29/20]

657—21.3(124,155A) System security and safeguards. To maintain the integrity and confidentiality of patient records and prescription drug orders, any system, computer, or electronic device 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. Authentication credentials shall be securely maintained by the individual to whom the credentials are issued and shall not be shared with or disclosed to any other individual. Once a drug or device has been dispensed, any alterations in either the prescription drug order data or the patient record shall be documented and shall include the identification of all pharmacy personnel who were involved in making the alteration as well as the responsible pharmacist. An automated data processing system used for the receipt and processing of electronic transmissions from a prescriber’s electronic prescription application shall comply with DEA requirements relating to electronic prescriptions and shall be certified compliant with DEA regulations.
[ARC 3640C, IAB 2/14/18, effective 3/21/18]

657—21.4 Reserved.

657—21.5(124,155A) Automated data processing systems. An automated data processing system may be used, subject to the requirements contained in this rule, for the storage and retrieval of prescription, patient, prescriber and drug data as well as data relating to the pharmacy staff utilization of the system.

21.5(1) *Electronic storage of hard-copy prescriptions.* A pharmacy that maintains an electronic copy of an original hard-copy prescription for a noncontrolled substance shall retain, in a readily retrievable format, the original hard-copy prescription as required in rule 657—6.8(155A) but shall be exempt from the requirement to record on the original hard-copy prescription the date and unique identification number of the prescription.

21.5(2) *Data retrievable and printable.* Any automated data processing system shall be capable of immediate retrieval (via computer monitor or hard-copy printout) of, at a minimum, any prescription, patient, prescriber, and drug data as well as data relating to pharmacy staff utilization of the system.

21.5(3) *Auxiliary procedure for system downtime.* A pharmacy utilizing an automated data processing system shall have a procedure that will maintain security and confidentiality of all data as well as ensure the legal dispensing of any prescription drug order in the event the system experiences downtime.

[ARC 3640C, IAB 2/14/18, effective 3/21/18]

657—21.6(124,155A) Electronic prescription applications. Beginning January 1, 2020, each prescription for a controlled substance shall be transmitted electronically to a pharmacy except as provided in rule 657—21.8(124,155A). Prior to January 1, 2020, a prescriber may, but shall not be required to, initiate and authorize a prescription drug order utilizing an electronic prescription application that has been determined to maintain security and confidentiality of patient information and records and, if prescribing controlled substances via an electronic prescribing system, certified compliant with DEA regulations for electronic prescribing of controlled substances. The prescription

drug order shall contain all information required by Iowa Code sections 155A.27 and 147.107(5). The receiving pharmacist shall be responsible for verifying the authenticity of an electronically prescribed prescription pursuant to rule 657—8.19(124,126,155A). A prescription that is electronically generated prior to January 1, 2020, or subject to exemption as provided in rule 657—21.8(124,155A), may be transmitted to a pharmacy via electronic or facsimile transmission or printed in hard-copy format for delivery to the pharmacy. A prescription that is transmitted by a prescriber's agent via electronic or facsimile transmission shall include the first and last names and title of the agent responsible for the transmission.

21.6(1) *Electronic transmission.* Beginning January 1, 2020, a prescription prepared pursuant to this rule shall be transmitted electronically to a pharmacy, unless exempt pursuant to rule 657—21.8(124,155A). A pharmacy shall be certified compliant with DEA regulations relating to electronic prescriptions prior to electronically receiving prescriptions for controlled substances. The electronic record shall serve as the original record and shall be maintained for two years from the date of last activity on the prescription. Any annotations shall be made and retained on the electronic record.

a. An electronically prepared and transmitted prescription that is printed following transmission shall be clearly labeled as a copy, not valid for dispensing.

b. The authenticity of a prescription transmitted via electronic transmission between a DEA-certified electronic prescription application and a DEA-certified electronic automated data processing system shall be deemed verified by virtue of the security processes included in those applications.

c. A pharmacy shall ensure that no intermediary has the ability to change the content of the prescription drug order or compromise its confidentiality during the transmission process. The electronic format of the prescription drug order may be changed by the intermediary to facilitate the transmission between electronic applications as long as the content of the prescription drug order remains unchanged.

d. In addition to the information requirements for a prescription, an electronically transmitted prescription shall identify the transmitter's telephone number for verbal confirmation, the time and date of transmission, and the pharmacy intended to receive the transmission as well as any other information required by federal or state laws, rules, or regulations.

e. If the transmission of an electronic prescription fails, the prescriber may print the prescription, manually sign the printed prescription, and deliver the prescription to the pharmacy via facsimile transmission in accordance with subrule 21.6(2).

21.6(2) *Printed (hard-copy) prescriptions.* A prescription electronically generated prior to January 1, 2020, or a prescription that is exempt from the electronic prescription mandate as provided in rule 657—21.8(124,155A), may be printed in hard-copy format for facsimile transmission or delivery to the pharmacy.

a. A prescription for a controlled substance shall include the prescriber's manual signature. Printed or hard-copy prescriptions for Schedule II controlled substances shall not be transmitted to a pharmacy via facsimile transmission, except as authorized in rule 657—21.7(124,155A).

b. If the prescriber authenticates a prescription for a noncontrolled prescription drug utilizing an electronic signature, the printed prescription shall be printed on security paper. Security features of the paper shall ensure that prescription information is not obscured or rendered illegible when transmitted via facsimile or when scanned into an electronic record system.

c. If the facsimile transmission of a printed prescription is a result of a failed electronic transmission, the facsimile shall indicate that it was originally transmitted to the named pharmacy, the date and time of the original electronic transmission, and the fact that the original transmission failed.

[ARC 3640C, IAB 2/14/18, effective 3/21/18; ARC 4580C, IAB 7/31/19, effective 9/4/19]

657—21.7(124,155A) *Facsimile transmission of a prescription.* A pharmacist may dispense noncontrolled and controlled drugs, including Schedule II controlled substances only as provided in this rule, pursuant to a prescription faxed to the pharmacy by the prescribing practitioner or the practitioner's agent. The means of transmission via facsimile shall ensure that prescription information is not obscured or rendered illegible due to security features of the paper utilized by the prescriber

to prepare a written prescription. The faxed prescription shall serve as the original record, except as provided in subrule 21.7(1), shall be maintained for a minimum of two years from the date of the last activity on the prescription, and shall contain all information required by Iowa Code sections 155A.27 and 147.107(5), including the prescriber's signature. If the prescription is transmitted by an agent of the prescriber, the facsimile transmission shall include the first and last names and title of the agent responsible for the transmission. The pharmacist shall be responsible for verifying the authenticity of the prescription as to the source of the facsimile transmission.

21.7(1) *Schedule II controlled substances—emergency situations.* A pharmacist may, in an emergency situation as defined in 657—subrule 10.26(1), dispense a Schedule II controlled substance pursuant to a facsimile transmission to the pharmacy of a written, signed prescription from the prescriber or the prescriber's agent pursuant to the requirements of rule 657—10.26(124). The facsimile shall serve as the temporary written record required by 657—subrule 10.26(2).

21.7(2) *Schedule II controlled substances—compounded injectable.* A prescription for a Schedule II narcotic substance to be compounded for the direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous, or intraspinal infusion may be transmitted by a prescriber or the prescriber's agent to a pharmacy via facsimile.

21.7(3) *Schedule II controlled substances—long-term care facility patients.* A prescription for any Schedule II controlled substance for a resident of a long-term care facility, as "long-term care facility" is defined in rule 657—23.1(155A), may be transmitted by the prescriber or the prescriber's agent to a pharmacy via facsimile. The prescription shall identify that the patient is a resident of a long-term care facility.

21.7(4) *Schedule II controlled substances—hospice patients.* A prescription for any Schedule II controlled substance for a patient in a hospice program licensed pursuant to Iowa Code chapter 135J or a program certified or paid for by Medicare under Title XVIII may be transmitted via facsimile by the prescriber or the prescriber's agent to the pharmacy. The prescription shall identify that the patient is a hospice patient.

[ARC 3640C, IAB 2/14/18, effective 3/21/18]

657—21.8(124,155A) Electronic prescription mandate and exemptions. Beginning January 1, 2020, all prescriptions shall be transmitted electronically to a pharmacy except as provided in this rule.

21.8(1) *Prescriptions exempt.* Prescriptions which shall be exempt from electronic transmission include:

- a. A prescription for a patient residing in a nursing home, long-term care facility, correctional facility, or jail.
- b. A prescription authorized by a licensed veterinarian.
- c. A prescription for a device.
- d. A prescription dispensed by a department of veterans affairs pharmacy.
- e. A prescription requiring information that makes electronic transmission impractical, such as complicated or lengthy directions for use or attachments.
- f. A prescription for a compounded preparation containing two or more components.
- g. A prescription issued in response to a public health emergency in a situation where a non-patient-specific prescription would be permitted.
- h. A prescription issued for an opioid antagonist pursuant to Iowa Code section 135.190 or a prescription issued for epinephrine pursuant to Iowa Code section 135.185.
- i. A prescription issued during a temporary technical or electronic failure at the location of the prescriber or pharmacy, provided that a prescription issued pursuant to this paragraph shall indicate on the prescription that the prescriber or pharmacy is experiencing a temporary technical or electronic failure.
- j. A prescription issued pursuant to an established and valid collaborative practice agreement, standing order, or drug research protocol.
- k. A prescription issued in an emergency situation pursuant to federal law and regulation and rules of the board. An emergency situation may include, but is not limited to, the issuance of a prescription to meet the immediate care need of a patient after hours when a prescriber is unable to access electronic

prescribing capabilities. Such prescription shall be limited to a quantity sufficient to meet the acute need of the patient with no authorized refills.

21.8(2) *Prescriber, medical group, institution, or pharmacy exemption.* A prescriber, medical group, institution, or pharmacy which has been granted an exemption to the electronic prescription mandate pursuant to rule 657—21.9(124,155A) shall be exempt from the electronic prescription mandate only for the duration of the approved exemption. Upon expiration of an approved exemption, the prescriber, medical group, institution, or pharmacy shall either comply with the electronic prescription mandate or timely petition the board for renewal of the exemption pursuant to rule 657—21.9(124,155A).

[ARC 4580C, IAB 7/31/19, effective 9/4/19]

657—21.9(124,155A) Exemption from electronic prescription mandate—petition. A prescriber, medical group, institution, or pharmacy that is unable to comply with the electronic prescription mandate in rule 657—21.8(124,155A) prior to January 1, 2020, may petition the board, on forms provided by the board, for an exemption from the requirements based upon economic hardship; technical limitations that the prescriber, medical group, institution, or pharmacy cannot control; or other exceptional circumstances. A prescriber, medical group, institution, or pharmacy seeking an exemption beginning January 1, 2020, shall submit a completed petition no later than October 1, 2019. A timely petition for renewal of a previously approved exemption shall be submitted at least 60 days in advance of the expiration of the previously approved exemption.

21.9(1) *Petition information.* A petition for exemption from the electronic prescription mandate shall include, but not be limited to, all of the following:

a. The name and address of the prescriber, medical group, institution, or pharmacy seeking the exemption. For medical groups and institutions, a list of the names, professional license numbers, and CSA registration numbers of all prescribers who would be covered by the exemption.

b. Whether the petitioner is seeking an exemption for controlled substance prescriptions, non-controlled substance prescriptions, or both.

c. The petitioner's current electronic prescribing capabilities.

d. The reason, such as economic hardship, technological limitations, or other exceptional circumstances, the petitioner is seeking exemption.

e. Supporting documentation to justify the reason for the exemption, including the following mandatory documentation:

(1) For economic hardship petitions, a copy of the petitioner's most recent tax return showing annual income and at least two quotes documenting the cost of implementing electronic prescribing.

(2) For technological limitation petitions, documentation showing the available Internet service providers, the speed and bandwidth available from each provider, and any data caps imposed by the Internet service provider, and documentation showing the minimum technological requirements from at least two electronic prescribing platform vendors.

f. Anticipated date of compliance with the electronic prescription mandate.

g. If the petition seeks renewal of a previously approved exemption, information relating to the petitioner's actions during the previous exemption period to work toward compliance with the electronic prescription mandate or an explanation as to why no progress has been made.

21.9(2) *Criteria for board consideration of a petition.* The board shall consider all information provided in a petition seeking exemption to the electronic prescription mandate and shall approve or deny a petition for exemption based on the following criteria:

a. If the reason for exemption is economic hardship, whether the cost of compliance with the electronic prescription mandate would exceed 5 percent of the petitioner's annual income as reported on the petitioner's most recent tax return.

b. If the reason for exemption is technological limitations, whether the Internet service providers available have the technological capabilities required by the electronic prescribing platform.

c. If the reason for exemption is other exceptional circumstances, examples of exceptional circumstances include, but are not limited to, whether the petitioner is a free or low-income clinic, whether the petitioner had a bankruptcy in the previous year, whether the petitioner intends to

discontinue practice in Iowa prior to December 31, 2020, and whether the petitioner has a disability that limits the ability to utilize an electronic prescribing platform. All other exceptional circumstances will be evaluated on a case-by-case basis.

d. If the petition seeks renewal of a previous exemption to the electronic prescription mandate, the number of exemptions previously granted and updated information as it relates to the petitioner working toward compliance with the electronic prescription mandate or the explanation as to why no progress has been made.

21.9(3) *Duration of approved exemption.* The board may approve an exemption, or the renewal of an exemption, to the electronic prescription mandate for a specified period of time not to exceed one year from the date of approval.

[ARC 4580C, IAB 7/31/19, effective 9/4/19]

657—21.10(124,155A) Automated medication distribution system (AMDS). Any pharmacy that utilizes an AMDS shall comply with these rules in addition to all applicable federal and state laws, rules, and regulations.

21.10(1) *Policies and procedures.* Pursuant to the requirements regarding policies and procedures in 657—subrule 8.3(5), each pharmacy utilizing an AMDS shall have policies and procedures that address all aspects of the operation of the AMDS to include, at a minimum:

- a.* Access to drugs and patient information,
- b.* Pharmacy personnel training in the proper operation of the AMDS,
- c.* Methods to ensure accurate stocking of the AMDS pursuant to subrule 21.10(2),
- d.* Confidentiality of patient information,
- e.* Routine and preventative maintenance of the AMDS according to manufacturer recommendations,
- f.* Packaging and labeling of prescription drugs loaded into or dispensed from the AMDS that is in compliance with federal and state laws, rules, and regulations, and
- g.* Security and control of the prescription drugs maintained and utilized in the AMDS to include:
 - (1) Drug loading, storage, and records.
 - (2) Drugs removed from system components but not used.
 - (3) Inventory.
 - (4) Cross contamination.
 - (5) Lot number control.
 - (6) Wasted or discarded drugs.
 - (7) Controlled substances.

21.10(2) *Stocking the AMDS.* The pharmacy shall have adequate procedures in place to ensure the accurate stocking of drugs into an AMDS using barcode scanning technology. Only a pharmacy technician, pharmacist-intern, or pharmacist shall be allowed to participate in the stocking of the AMDS.

21.10(3) *Pharmacist verification of drugs dispensed from AMDS.*

a. When an AMDS only dispenses drugs that were prepackaged and verified by a pharmacist prior to being stocked in the AMDS and there was no further manipulation of the drug or package other than affixing a patient-specific label, such drugs shall not require additional pharmacist verification prior to administration or dispensing to the patient or authorized representative.

b. When a drug is stocked in an AMDS and undergoes further manipulation, such as counting and packaging, such drugs shall require pharmacist verification prior to dispensing to the patient. Such verification shall be documented.

21.10(4) *Placement of AMDS.*

a. An AMDS placed outside a pharmacist's direct supervision shall only dispense pharmacist-verified packages in compliance with paragraph 21.10(3) "a."

b. An AMDS that manipulates, including but not limited to counting, packaging, or labeling, prescription drugs for subsequent patient dispensing shall only be utilized in a pharmacy under the direct supervision of a pharmacist, except in an approved telepharmacy pursuant to 657—Chapter 13.

[ARC 3640C, IAB 2/14/18, effective 3/21/18]

657—21.11(124,155A) Pharmacist verification of controlled substance fills—daily printout or logbook. The individual pharmacist who makes use of the pharmacy prescription application shall provide documentation of the fact that the fill information entered into the pharmacy prescription application each time the pharmacist fills a prescription order for a controlled substance is correct. If the pharmacy prescription application provides a hard-copy printout of each day's controlled substance prescription order fill data, that printout shall be verified, dated, and signed by each individual pharmacist who filled a controlled substance prescription order. Each individual pharmacist must verify that the data indicated is correct and sign this document in the same manner as the pharmacist would sign a check or legal document (e.g., J. H. Smith or John H. Smith). This document shall be maintained in a separate file at that pharmacy for a period of two years from the dispensing date. This printout of the day's controlled substance prescription order fill data shall be generated by and available at each pharmacy using a computerized pharmacy prescription application within 48 hours of the date on which the prescription was dispensed. The printout shall be verified and signed by each pharmacist involved with such dispensing. In lieu of preparing and maintaining printouts as provided above, the pharmacy may maintain a bound logbook or separate file. The logbook or file shall include a statement signed each day by each individual pharmacist involved in each day's dispensing that attests to the fact that the prescription information entered into the pharmacy prescription application that day has been reviewed by the pharmacist and is correct as shown. Pharmacist statements shall be signed in the manner previously described. The logbook or file shall be maintained at the pharmacy for a period of two years after the date of dispensing.

[ARC 3640C, IAB 2/14/18, effective 3/21/18]

These rules are intended to implement Iowa Code sections 124.301, 124.306, 124.308, 147.107, 155A.27, 155A.33, and 155A.35.

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CHAPTER 42
LIMITED DISTRIBUTOR LICENSES

657—42.1(155A) Purpose and scope. The purpose of this chapter is to establish the minimum standard of practice for limited drug and device distribution in the state of Iowa. This chapter applies to a person who is involved in the distribution of drugs and devices but who does not meet the definition of a wholesale distributor under federal or state law. In addition to the rules of the board, any distribution of prescription drugs and devices shall be in compliance with all applicable federal and state laws and regulations.

[ARC 4191C, IAB 12/19/18, effective 1/23/19]

657—42.2(155A) Definitions. In addition to the definitions found in Iowa Code section 155A.3, which are adopted for the purposes of this chapter, the following definitions shall apply:

“*Board*” means the Iowa board of pharmacy.

“*Distribute*” means the delivery or transfer of a prescription drug or device from one person to another.

“*Facility manager*” means the individual responsible for managing the daily operations of the limited distributor facility.

“*Limited distributor*” means a person operating or maintaining a location, regardless of the location, where prescription drugs or devices are manufactured, repackaged, distributed at wholesale, or distributed to a patient pursuant to a prescription drug order, who is not eligible for a wholesale distributor license or a pharmacy license. Included in the definition of “limited distributor” are the activities identified in subrule 42.3(1).

[ARC 4191C, IAB 12/19/18, effective 1/23/19]

657—42.3(155A) Limited distributor license. Beginning January 1, 2019, no person other than a licensed wholesale distributor, licensed pharmacy, or practitioner shall engage in any of the activities found herein in this state without a limited distributor license. Where operations are conducted at more than one location by a single distributor, each location shall be separately licensed. The applicant shall submit a completed application along with a nonrefundable fee of \$175. A limited distributor that engages in distribution of controlled substances into, out of, or within this state shall also obtain a controlled substances Act registration pursuant to 657—Chapter 10.

42.3(1) License required. A person engaged in the following activities shall obtain a limited distributor license prior to distribution in or into Iowa:

a. Distribution of a medical gas or device at wholesale or to a patient pursuant to a prescription drug order.

b. Wholesale distribution of a prescription animal drug.

c. Wholesale distribution of a prescription drug, or brokering the distribution of a prescription drug at wholesale, by a manufacturer, a manufacturer’s co-licensed partner, or a repackager.

d. Intracompany distribution of a prescription drug, including pharmacy chain distribution centers.

e. Distribution at wholesale of a combination product as defined by the United States Food and Drug Administration, medical convenience kit, intravenous fluid or electrolyte, dialysis solution, radioactive drug, or irrigation or sterile water solution to be dispensed by prescription only.

f. Distribution of a dialysis solution by the manufacturer or the manufacturer’s agent to a patient pursuant to a prescription drug order, provided that a licensed pharmacy processes the prescription drug order.

42.3(2) License optional. A person engaged in the following activities may, but is not required to, obtain a limited distributor license for distribution in or into Iowa:

a. Distribution of nonprescription drugs or devices with or without a patient-specific prescription.

b. Distribution of medical devices exclusively to a health care practitioner for use in the normal course of professional practice (“professional use”).

c. Distribution of blood and blood products that are not subject to the federal Drug Supply Chain Security Act (DSCSA).

42.3(3) Application. The applicant shall complete an application which requires demographic information about the limited distributor, ownership information, information about the limited distributor's registered agent located in Iowa, information about the limited distributor's licensure with other state and federal regulatory authorities, criminal and disciplinary history information, information regarding the facility manager, and a detailed description of the services to be provided in this state. An application for a limited distributor 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, including opening for business, within six months of receipt by the board of the required application(s). The following shall also be submitted by the applicant for the application to be considered complete:

a. Evidence of the mandatory physical inspection of the distribution facility pursuant to subrule 42.3(7).

b. Attestation by facility manager. The applicant shall submit attestation that the facility manager has adequate experience in prescription drug and device distribution; is actively involved in the daily operation of the distribution facility; maintains a functional understanding of federal and state laws, rules, and regulations pertaining to drug and device distribution, as applicable; and has no felony convictions or convictions related to prescription drug and device distribution, including distribution of controlled substances.

42.3(4) License renewal. A limited distributor license shall be renewed before January 1 of each year and may be renewed as early as November 1 prior to expiration. The limited distributor shall submit a completed application and nonrefundable application fee as required in this rule.

a. Delinquent license grace period. If a limited distributor license has not been renewed or canceled prior to expiration, the license becomes delinquent on January 1. A limited distributor that submits a completed license renewal application, nonrefundable application fee, and nonrefundable late penalty fee of \$175 postmarked or delivered to the board by January 31 shall not be subject to disciplinary action for continuing to provide services in this state in the month of January.

b. Delinquent license reactivation beyond grace period. If a limited distributor license has not been renewed prior to the expiration date of the one-month grace period identified in paragraph 42.3(4)“a,” the limited distributor may not operate or do business in Iowa, unless the activities conducted are those identified in subrule 42.3(2). A limited distributor that continues to do business in Iowa without a current license as required in subrule 42.3(1) may be subject to disciplinary sanctions pursuant to the provisions of 657—subrule 36.6(2). A limited distributor without a current license may apply for reactivation by submitting a license application for reactivation and a nonrefundable reactivation fee of \$500. As part of the reactivation application, the limited distributor shall disclose the services, if any, that were provided in this state while the license was delinquent.

42.3(5) License changes. If a distributor has a change of name, ownership, or location, a limited distributor license application with a nonrefundable application fee as provided in subrule 42.3(3) shall be submitted to the board. A change of ownership occurs when the owner listed on the limited distributor's most recent application changes or when there is a change affecting the majority ownership interest of the owner listed on the limited distributor's most recent application. A change of limited distributor location within Iowa, if the new location was not a licensed limited distributor immediately prior to the relocation, shall require a self-inspection as provided in subrule 42.3(7). A limited distributor that has submitted a license change application may continue to service Iowa customers while its license change is pending final approval.

a. For a distributor located in Iowa, a completed application shall be submitted to the board as far in advance as possible prior to the change of name, ownership, or location.

b. For a distributor located outside of Iowa:

(1) If the home state licenses or registers the facility, a completed application shall be submitted within ten days of receipt of an updated license or registration from the home state.

(2) If the home state does not license or register the facility, a completed application shall be submitted as far in advance as possible prior to the change of name, ownership, or location.

c. When a distributor changes its name or location, the distributor shall provide advance written notice of the change to each Iowa customer and patient.

d. Applications for license changes shall be timely submitted pursuant to this subrule. A licensed limited distributor that has timely submitted a license change application and fee may continue to service Iowa customers while the license change is pending final approval. An applicant that has submitted an application for license changes after the required date of submission pursuant to this subrule but within 30 days of the required date of submission shall be assessed a nonrefundable late penalty fee of \$175 in addition to the license fee. An applicant that has submitted an application for license changes 31 days or later following the required date of submission pursuant to this subrule shall be assessed a nonrefundable reactivation fee of \$500.

42.3(6) License cancellation. If a limited distributor intends to discontinue service into, out of, or within this state, it shall:

a. Notify the board as far in advance as possible of the limited distributor's intent to discontinue services and shall request that the license be administratively canceled. The notification shall include the name, address, and Iowa license number of the pharmacy or distributor at which prescription, patient, and distribution records will be maintained.

b. Ensure that prescription and patient records are transferred to another Iowa-licensed distributor or pharmacy.

c. To the extent possible to avoid unnecessary delays in the availability of services to Iowa customers and patients, provide advance written notice to customers and patients of the date that the distributor intends to cease provision of services.

42.3(7) Inspection of limited distributor facility. Each limited distributor location seeking initial or renewal licensure shall, prior to issuance of a license certificate, complete and submit for evaluation a self-inspection packet provided by the board.

42.3(8) Change in facility manager. If a distributor has a change in facility manager, the licensee shall provide notice to the board on forms provided by the board within ten days of the change.

[ARC 4191C, IAB 12/19/18, effective 1/23/19; ARC 5008C, IAB 3/25/20, effective 4/29/20]

657—42.4 and 42.5 Reserved.

657—42.6(155A) Grounds for denial. The board may deny a limited distributor license application, or refuse to renew a license, for any of the following:

1. Any criminal convictions of the applicant related to the distribution of drugs or devices;
 2. Any felony convictions of the applicant;
 3. Insufficient experience in the distribution of prescription drugs or devices, including a lack of knowledge regarding the requirements of applicable federal and state laws or regulations;
 4. The furnishing of false or fraudulent material;
 5. Suspension, revocation, or other disciplinary action taken by the licensing authority of another state or federal agency against any license or registration currently or previously held by the applicant;
 6. Noncompliance with licensing requirements under previously granted licenses, if any;
 7. Noncompliance with the requirements to maintain or make available to the board, its agents, or to federal, state, or local law enforcement officials those records required to be maintained;
 8. Conducting transactions with a person that is not properly licensed, registered, or authorized;
- and
9. Any other factors or qualifications the board considers relevant to and consistent with public health and safety.

[ARC 4191C, IAB 12/19/18, effective 1/23/19]

657—42.7(155A) Policies and procedures.

42.7(1) Distributors shall have for all aspects of the distributor's operation policies and procedures that, at a minimum, address the rules in this chapter and any other applicable federal, state, and local laws, rules, and regulations.

42.7(2) The policies shall address, at a minimum:

- a. Security of the facility and of patient information;
- b. Storage of products, including proper storage conditions and handling of outdated, recalled, and returned products;
- c. Records, including the retention period for all required records;
- d. Security, storage and records for products in the possession of a distributor's authorized representative; and
- e. Employment of personnel with education and experience appropriate to the responsibilities of the position held.

[ARC 4191C, IAB 12/19/18, effective 1/23/19]

657—42.8 and 42.9 Reserved.

657—42.10(155A) Requirements.

42.10(1) Physical requirements. A distributor's location shall:

- a. Be of suitable size and construction to facilitate cleaning, maintenance, and proper operations;
- b. Have storage areas designed to provide adequate lighting, ventilation, temperature, sanitation, humidity, space, equipment, and security conditions;
- c. Have a quarantine area for storage of outdated, damaged, unsafe, deteriorated, misbranded, or adulterated products and for any suspect products;
- d. Be maintained in a clean and orderly condition;
- e. Be free from infestation by insects, rodents, birds, or vermin of any kind.

42.10(2) Operation requirements. Distributors shall operate in compliance with all applicable federal, state, and local laws, rules, and regulations.

a. *Purchasing.* Distributors shall purchase products from a legitimate source that is properly licensed in the state in which it is located and that is properly licensed in the distributor's home state, if such licensure is required. Distributors shall exercise due diligence in determining the legitimacy of a product's source and maintain documentation of the distributor's verification of the legitimate source.

b. *Examination of materials.* Distributors shall ensure, upon receipt and prior to distribution, that a product is suitable for distribution.

c. *Verification.* Qualified personnel shall verify, prior to distribution, that the product matches the order for which the product is being distributed.

d. *Instructions for use.* Qualified personnel shall provide to the patient or the patient's caregiver adequate instructions for use when a product is distributed pursuant to a prescription order.

[ARC 4191C, IAB 12/19/18, effective 1/23/19]

657—42.11 Reserved.

657—42.12(155A) Records. Distributors shall establish and maintain records of all transactions regarding the receipt and distribution or other disposition of products, including outdated, damaged, deteriorated, misbranded, or adulterated products.

42.12(1) Transaction records. Records for receipt and distribution transactions for all products shall include the following information:

- a. The source of the products, including the name and principal address of the seller or transferor and the address of the location from which the products were shipped;
- b. The identity and quantity of the products received or distributed;
- c. The date of receipt or distribution of the products; and
- d. The identity of the purchaser of the products, including the name and principal address of the purchaser or transferee and the address to which the products were shipped or distributed.

42.12(2) Prescription order records. Each prescription order that results in the distribution of a product shall be retained, in the original format received, and be available for inspection and copying by the board, its representative, or other authorized individual for at least two years from the date of last activity of the prescription order.

a. Prescription orders shall contain all the required elements identified in Iowa Code section 155A.27.

b. Prescription orders for noncontrolled prescription drugs shall be valid for no longer than 18 months following the date issued or 13 fills, whichever is less.

c. A one-month supply of a medical gas, such as oxygen, shall be considered to be a single refill. Such prescription must be reissued at least every 13 months.

d. Prescription orders for controlled substances shall be valid for no longer than six months following the date issued or six fills, whichever is less.

42.12(3) *Records maintained.* All records generated pursuant to the distributor's policies and procedures, this chapter, and all federal, state, and local rules, laws and regulations shall be maintained, readily retrievable, and available for inspection and copying by the board, its representative, or other authorized individual for at least two years from the date of the record.

42.12(4) *Confidentiality of patient information.* Any patient information in the possession of a distributor shall be maintained in compliance with the patient confidentiality and security requirements of 657—Chapter 8, 657—Chapter 21, and federal law.

[ARC 4191C, IAB 12/19/18, effective 1/23/19]

657—42.13 Reserved.

657—42.14(155A) Reporting discipline and criminal convictions. No later than 30 days after the final action, a limited distributor shall provide to the board written notice, including an unredacted copy of the action or order, of any disciplinary or enforcement action imposed by any licensing or regulatory authority on any license or registration held by the distributor. Discipline may include, but is not limited to, fine or civil penalty, citation or reprimand, probationary period, suspension, revocation, and voluntary surrender. No later than 30 days after the conviction, a limited distributor shall provide to the board written notice, including an unredacted copy of the judgment of conviction or sentence, of any criminal conviction of the distributor, any owner of the distributor, or any individual responsible for managing the daily operations of the distribution facility, if the conviction is related to prescription drug or device distribution. The term "criminal conviction" includes instances when the judgment of conviction or the sentence is deferred.

[ARC 4191C, IAB 12/19/18, effective 1/23/19]

657—42.15(155A) Discipline. Pursuant to 657—Chapter 36, the board may fine, suspend, revoke, or impose other disciplinary sanctions on a limited distributor license for any of the following:

1. Any violation of the federal Food, Drug, and Cosmetic Act or federal regulation promulgated under the Act. A warning letter issued by the United States Food and Drug Administration shall be conclusive evidence of a violation.

2. Any conviction of a crime related to the distribution of prescription drugs or devices committed by the distributor, its owners, or the facility manager.

3. Refusing access to the distribution facility or records to an agent of the board for the purpose of conducting an inspection or investigation.

4. Failure to maintain registration pursuant to 657—Chapter 10 when distributing controlled substances into, out of, or within this state.

5. Any act of unethical or unprofessional conduct by an employee of the distributor.

6. Any violation of Iowa Code chapter 124, 126, 155A, or 205, or rule of the board, including the disciplinary grounds set forth in 657—Chapter 36.

[ARC 4191C, IAB 12/19/18, effective 1/23/19]

These rules are intended to implement Iowa Code sections 124.301 through 124.308, 126.3, 126.9 through 126.12, 126.22, 155A.3, 155A.4, 155A.13, 155A.17, 155A.21, 155A.23, and 155A.42.

[Filed ARC 4191C (Notice ARC 3975C, IAB 8/29/18), IAB 12/19/18, effective 1/23/19]

[Filed ARC 5008C (Notice ARC 4691C, IAB 10/9/19), IAB 3/25/20, effective 4/29/20]

CHAPTER 43
THIRD-PARTY LOGISTICS PROVIDER LICENSES

657—43.1(155A) Purpose and scope. The purpose of this chapter is to establish the minimum standards required of third-party logistics providers as defined in Iowa Code section 155A.3 in this state pursuant to national standards as established by federal law. This chapter applies to logistics providers operating in or into this state. A 3PL does not include an entity that solely engages in shipping activities. Applicable activities of a 3PL include, but are not limited to, picking, packing, and shipping; inventory management; and warehousing or distribution management. In the event the requirements of this chapter directly conflict with any federal law or regulation, the federal law or regulation shall supersede the requirements in this chapter.

[ARC 4192C, IAB 12/19/18, effective 1/23/19]

657—43.2(155A) Definitions. For the purposes of this chapter, the definitions found in Iowa Code section 155A.3 and the following definitions apply.

“*Board*” means the Iowa board of pharmacy.

“*Facility manager*” means the individual who is responsible for the daily operation of a third-party logistics licensed location.

“*FDA*” means the United States Food and Drug Administration.

“*Home state*” means the state in which a third-party logistics provider is located.

“*Third-party logistics provider*” or “*3PL*” means an entity that provides or coordinates warehousing or other logistics services of a product in interstate commerce on behalf of a manufacturer, wholesale distributor, or dispenser of a product, but does not take ownership of the product nor have responsibility to direct the sale or other disposition of the product.

[ARC 4192C, IAB 12/19/18, effective 1/23/19]

657—43.3(155A) 3PL license. Beginning April 1, 2019, every 3PL as defined in rule 657—43.2(155A), wherever located, that provides or coordinates warehousing or other logistics services of products into, out of, or within this state must be licensed by the board in accordance with the laws and rules of Iowa before engaging in such logistics operations. Where activities are conducted at more than one location by a single 3PL, each location shall be separately licensed. The applicant shall submit a completed application with a nonrefundable application fee of \$750. A 3PL that handles controlled substances shall also obtain a controlled substances Act registration pursuant to 657—Chapter 10.

43.3(1) Application. The applicant shall complete an application which requires demographic information about the 3PL, ownership information, information about the 3PL’s registered agent located in Iowa, information about the 3PL’s licensure or registration with other state and federal regulatory authorities, criminal and disciplinary history information, and a description of the scope of services to be provided in Iowa. If the applicant is not located in Iowa, the applicant shall submit evidence that the applicant has a valid license or registration in the home state or provide evidence that the home state does not require licensure. The applicant shall provide evidence of current verified-accredited wholesale distributors (VAWD) accreditation by the National Association of Boards of Pharmacy. This requirement does not apply to new applicants located in Iowa which must undergo an opening inspection by a board compliance officer or agent of the board prior to issuance of an initial license pursuant to subrule 43.3(3). 3PL distributors located in Iowa shall provide evidence of VAWD accreditation on or before license renewal. An application for a 3PL 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, including opening for business, within six months of receipt by the board of the required application(s).

43.3(2) Facility manager. The applicant shall attest that the facility manager has adequate experience in providing or coordinating warehousing or other logistics services of products; is actively involved in the daily operation of the facility; maintains a functional understanding of federal and state laws, rules, and regulations pertaining to drug and device distribution; and has no felony conviction or convictions related to prescription drug or device distribution, including distribution of controlled substances. Upon

receipt of a licensure application, the board shall provide a fingerprint packet to the applicant's facility manager, who shall submit the completed fingerprint packet and a signed waiver form to facilitate a national criminal history background check of the facility manager. The cost of the evaluation of the fingerprint packet and the Iowa division of criminal investigation and the United States Federal Bureau of Investigation criminal history background checks will be assessed to the applicant.

43.3(3) Inspection of new 3PL facility. Each new 3PL location seeking licensure shall be inspected prior to issuance of a license.

a. Iowa location. If the applicant is located within Iowa, an inspection shall be conducted by the board or its authorized agent prior to issuance of the license and periodically thereafter.

b. Nonresident location. If the applicant is located outside of Iowa, an inspection shall be conducted by the applicant's home state regulatory authority or another board-approved inspecting authority and a report of such inspection shall be submitted with the application. The application shall also include evidence of corrective action taken to satisfy any deficiencies identified in the inspection report and compliance with all legal directives of the inspecting authority, if applicable. With each license renewal and license reactivation for a 3PL outside of Iowa, the application shall include a copy of the most recent inspection report issued as a result of an inspection conducted by the home state regulatory authority or other board-approved inspecting authority.

43.3(4) License renewal. The 3PL license shall be renewed by April 1 each year. The 3PL shall submit the completed license application and nonrefundable application fee of \$750. A 3PL may renew its license beginning February 1 prior to license renewal. An initial 3PL license issued between February 1 and March 31 shall not require renewal until the following calendar year.

a. Delinquent license grace period. If a 3PL license has not been renewed or canceled prior to expiration, but the 3PL is in the process of renewing the license, the license becomes delinquent on April 1. A 3PL that submits a completed license renewal application, nonrefundable application fee, and nonrefundable late penalty fee of \$750 postmarked or delivered to the board by April 30 shall not be subject to disciplinary action for continuing to provide services to Iowa customers in the month of April.

b. Delinquent license reactivation beyond grace period. If a 3PL license has not been renewed prior to the expiration of the one-month grace period identified in paragraph 43.3(4) "a," the 3PL may not continue to provide services to Iowa customers. A 3PL that continues to provide services to Iowa customers without a current license may be subject to disciplinary sanctions. A 3PL without a current license may apply for reactivation by submitting a license application for reactivation and a nonrefundable reactivation fee of \$2,000. As part of the reactivation application, the 3PL shall disclose the services, if any, that were provided to Iowa customers while the license was delinquent.

43.3(5) License changes. When a licensed 3PL changes its name, ownership, location, or facility manager, a completed 3PL license application with nonrefundable fee of \$750 shall be submitted to the board. A change of ownership occurs when the owner listed on the 3PL's most recent application changes or when there is a change affecting the majority ownership interest of the owner listed on the 3PL's most recent application. A change of 3PL location within Iowa, if the new location was not a licensed 3PL immediately prior to the relocation, shall require an on-site inspection of the new location as provided in subrule 43.3(3). A 3PL that has submitted a license change application may continue to service Iowa customers while its license change is pending final approval.

a. Locations in Iowa. An application for license change shall be submitted to the board as far in advance as possible prior to the anticipated change.

b. Locations outside of Iowa. An application for license change shall be submitted to the board within ten days of the 3PL's receipt of an updated license or registration from the home state regulatory authority or the FDA, as applicable.

c. License change application submission. Applications for license changes shall be timely submitted pursuant to this subrule. A licensed 3PL that has timely submitted a license change application and fee may continue to service Iowa customers while the license change is pending final approval. An applicant that has submitted an application for license changes after the required date of submission pursuant to this subrule but within 30 days of the required date of submission shall be assessed a nonrefundable late penalty fee of \$750 in addition to the license fee. An applicant that has

submitted an application for license changes 31 days or later following the required date of submission pursuant to this subrule shall be assessed a nonrefundable reactivation fee of \$2,000.

d. Change in facility manager. When a 3PL has a change in facility manager, a new facility manager shall be identified pursuant to this paragraph. If a permanent facility manager is not currently the facility manager of a licensed facility, the facility manager shall submit to a criminal background check.

(1) If a permanent facility manager has been identified at the time of the vacancy, a 3PL license application identifying the new permanent facility manager, along with the appropriate fee, shall be submitted to the board within ten days of the vacancy.

(2) If no permanent facility manager has been identified at the time of the vacancy, a temporary facility manager shall be identified and notice of such shall be submitted in writing to the board within ten days of the vacancy. A temporary facility manager shall not be required to submit a fingerprint packet and signed waiver to facilitate a national criminal history check unless the temporary facility manager subsequently is identified as the permanent facility manager. Within 90 days of the vacancy, a permanent facility manager shall be identified and a 3PL license application identifying the permanent facility manager, along with the appropriate fee, shall be submitted to the board.

43.3(6) License cancellation. If a 3PL intends to discontinue service into, out of, or within this state, the licensee shall notify the board and shall request that the license be administratively canceled. [ARC 4192C, IAB 12/19/18, effective 1/23/19; ARC 5008C, IAB 3/25/20, effective 4/29/20]

657—43.4 Reserved.

657—43.5(155A) Compliance with federal and state laws. A 3PL is responsible for complying with all applicable federal and state laws, including those not specifically identified in this chapter.

1. A licensed 3PL shall meet the requirements set forth in the Drug Supply Chain Security Act, 21 U.S.C. §360eee-3, relating to third-party logistics and regulations promulgated thereunder.

2. A licensed 3PL shall permit agents of the board to enter and inspect the facility for compliance with federal and state laws. A licensed 3PL shall cooperate with other regulatory or law enforcement officials with jurisdiction over the facility.

[ARC 4192C, IAB 12/19/18, effective 1/23/19]

657—43.6(155A) Policies and procedures. A licensed 3PL shall establish, maintain, and adhere to written policies and procedures that are in compliance with standards established pursuant to federal and Iowa law and which address, at a minimum, the following:

1. Storage practices;
2. Maintaining adequate security;
3. Receipt, inventory, shipment, and distribution of product;
4. Theft or loss;
5. Inventory errors and inaccuracies;
6. Manufacturer recalls and withdrawals;
7. Emergency and disaster plan;
8. Records, including the retention period for all required records;
9. Drug diversion detection and prevention; and
10. Outdated, adulterated, or suspect products.

[ARC 4192C, IAB 12/19/18, effective 1/23/19]

657—43.7 and 43.8 Reserved.

657—43.9(155A) Reporting discipline and criminal conviction. No later than 30 days after the final action, a 3PL shall provide to the board written notice, including an unredacted copy of the action or order, of any disciplinary sanction imposed on any license or registration held by the 3PL or its owner or owners. Discipline may include, but is not limited to, fine or civil penalty, citation or reprimand, probationary period, suspension, revocation, and voluntary surrender. No later than 30 days after the conviction, a 3PL

shall provide to the board written notice, including an unredacted copy of the judgment of conviction or sentence, of any criminal convictions related to product distribution, including convictions of any of its owners, or its facility manager. The term “criminal conviction” includes instances when the judgment of conviction or the sentence is deferred.

[ARC 4192C, IAB 12/19/18, effective 1/23/19]

657—43.10(155A) Discipline. Pursuant to 657—Chapter 36, the board may fine, suspend, revoke, or impose other disciplinary sanctions on a 3PL license for any of the following:

1. Any violation of the federal Food, Drug, and Cosmetic Act or federal regulation promulgated under the Act related to third-party logistics and drug or device distribution.
2. Any conviction of a crime related to the distribution of prescription drugs or devices committed by the 3PL, its owners, or the facility manager.
3. Refusing access to the 3PL facility or records to an agent of the board or other authorized regulatory authority for the purpose of conducting an inspection or investigation.
4. Failure to maintain registration pursuant to 657—Chapter 10 when distributing controlled substances into, out of, or within this state.
5. Any act of unethical or unprofessional conduct by an employee of the 3PL.
6. Any violation of Iowa Code chapter 124, 126, 155A, or 205, or rule of the board, including the disciplinary grounds set forth in 657—Chapter 36.

[ARC 4192C, IAB 12/19/18, effective 1/23/19]

These rules are intended to implement Iowa Code chapter 124B and sections 124.301 through 124.308, 126.3, 126.9 through 126.12, 155A.3, 155A.4, 155A.17A, and 155A.40 and the federal Drug Supply Chain Security Act.

[Filed ARC 4192C (Notice ARC 3976C, IAB 8/29/18), IAB 12/19/18, effective 1/23/19]

[Filed ARC 5008C (Notice ARC 4691C, IAB 10/9/19), IAB 3/25/20, effective 4/29/20]

CHAPTER 14
VETERANS TRUST FUND

801—14.1(35A) Purpose. These rules establish the requirements for veterans or their spouses or dependents to receive benefits from the veterans trust fund.

801—14.2(35A) Definition. For purposes of this chapter, “veteran” means the same as defined in Iowa Code section 35.1, or a resident of Iowa who served in the armed forces of the United States, completed a minimum aggregate of 90 days of active federal service, other than training, and was discharged under honorable conditions, or a former member of the national guard, reserve, or regular component of the armed forces of the United States who was honorably discharged due to injuries incurred while on active federal service that precluded completion of a minimum aggregate of 90 days of active federal service, other than training.

[ARC 7823B, IAB 6/3/09, effective 7/8/09]

801—14.3(35A) Eligibility. Veterans, their spouses, and their dependents applying for benefits available under subrules 14.4(1) through 14.4(9) must meet the following threshold requirements.

14.3(1) Income. For the purposes of this chapter, an applicant’s household income, including VA pension benefits, service-connected disability income, and social security income, shall not exceed 200 percent of the federal poverty guidelines for the number of family members living in the primary residence in effect on the date the application is received by the county director of veterans affairs. Federal poverty guidelines shall be those guidelines established by the Iowa department of human services for the veteran’s family size. The commission shall adjust the guidelines on July 1 of each year to reflect the most recent federal poverty guidelines. The commission may waive the income threshold if all income is from a fixed source and all other sources of assistance have been exhausted.

14.3(2) Resources. The department may not pay benefits under this chapter if the available liquid assets of the veteran are in excess of \$15,000. For the purposes of this chapter, “available liquid assets” means cash on hand, cash in a checking or savings account, stocks, bonds, certificates of deposit, treasury bills, money market funds and other liquid investments owned individually or jointly by the applicant and the applicant’s spouse, unless the applicant and spouse are separated or are in the process of obtaining a divorce, but does not include funds deposited in IRAs, Keogh plans or deferred compensation plans, unless the veteran is eligible to withdraw such funds without incurring a penalty. Cash surrender value of life insurance policies, real property, established burial account, or a personal vehicle shall not be included as available liquid assets.

14.3(3) Funding from other sources. Applications shall not be approved if the applicant is eligible to receive aid from other sources to meet the purposes authorized in this chapter.

14.3(4) Additional requirements and limitations. Applicants must meet any additional requirements and are subject to any limitations which may be set out in this chapter or which may be established for a particular benefit.

[ARC 7823B, IAB 6/3/09, effective 7/8/09; ARC 0057C, IAB 4/4/12, effective 5/9/12]

801—14.4(35A) Benefits available. Applications may be approved for any of the following purposes. By a majority vote, the commission may suspend some or all of these benefits for payment.

14.4(1) Travel expenses for wounded veterans, and their spouses, directly related to follow-up medical care. Travel expenses under this subrule include the unreimbursed cost of airfare, lodging, and a per diem of \$25 per day for required out-of-state medical travel that exceeds 125 miles from the veteran’s home. Spouses may be reimbursed for in-state lodging and a per diem of \$25 per day when visiting a veteran who is in a hospital for medical care related to a service-connected disability. The distance from the veteran’s home to the hospital must exceed 100 miles. The veteran or the veteran’s spouse shall provide such evidence as the commission may require, which includes but is not limited to evidence the injury or disability is service-connected, the necessity of treatment in a particular facility, and documentation of expenses. The maximum amount for lodging reimbursement shall be \$90. The

maximum amount of aid payable in a consecutive 12-month period under this subrule is \$1,000. The commission may waive the income threshold for this benefit.

14.4(2) *Job training or college tuition assistance for job retraining.*

a. The commission may pay a veteran not more than \$3,000 for retraining or postsecondary education to enable the veteran to obtain gainful employment. The commission may provide aid under this subrule if all of the following apply:

(1) The veteran is enrolled in a training course in a technical college or school, is enrolled in an accredited postsecondary institution, or is engaged in a structured on-the-job training program.

(2) The veteran is unemployed, underemployed, or has received a notice of termination of employment.

(3) The commission determines that the veteran's proposed program, or current program, will provide retraining or initial training that could enable the veteran to find gainful employment. In making its determination, the commission shall consider whether the proposed program, or current program, provides adequate employment skills and is in an occupation for which favorable employment opportunities are anticipated.

(4) The veteran requesting aid has not received full reimbursement or payment from any other retraining or education scholarship programs and the veteran does not have other assets or income available to meet retraining or initial training expenses. Applicants requesting aid under this subrule will only be granted the unpaid portion of their tuition statement, and the payment will be made directly to the institution.

b. The veteran shall provide such evidence as the commission may require to satisfy the requirements of this subrule.

14.4(3) *Unemployment or underemployment assistance during a period of unemployment or underemployment due to prolonged physical or mental illness resulting from military service or disability resulting from military service (must be physically and mentally able to return to work).* The commission may provide subsistence payments only to a veteran who has suffered a loss of income due to prolonged physical or mental illness resulting from military service or disability resulting from military service. The commission may provide subsistence payments of up to \$500 per month of unemployment or underemployment to a veteran. A veteran must provide documentation of assistance from Iowa workforce development and vocational rehabilitation, if eligible. No payment may be made under this subrule if the veteran has other assets or income available to meet basic subsistence needs. A period of unemployment implies that it is possible for the veteran to be employed in the future. A rating from the VA of 100 percent due to individual unemployability (IU) rated permanent and total indicates that a veteran is unemployable and will not qualify for assistance under this subrule. The veteran shall provide such evidence as the commission may require, which includes but is not limited to evidence that the mental illness or disability is service-connected and evidence that the veteran is unemployed or underemployed for the period of payments. To qualify as underemployed, the applicant must be currently working at an income that is below 150 percent of federal poverty guidelines due to limitations caused by the applicant's service-connected disability or illness. The maximum amount of aid payable in a consecutive 12-month period under this subrule is \$3,000 and a lifetime maximum of \$6,000.

14.4(4) *Expenses related to hearing care, dental care, vision care, or prescription drugs.*

a. The commission may provide health care aid to a veteran, to the veteran's spouse or dependents, or to the unremarried spouse of a deceased veteran for dental care, including dentures; vision care, including eyeglass frames and lenses; hearing care, including hearing aids; and prescription drugs that are not covered by the veterans affairs medical center.

b. The maximum amount that may be paid under this subrule for any consecutive 12-month period may not exceed \$10,000 for dental care, \$500 for vision care, \$1,500 per ear for hearing care, and \$1,500 for prescription drugs. Lifetime maximum benefit: \$10,000.

c. The commission shall not provide health care aid under this subrule unless the aid recipient's health care provider agrees to accept, as full payment for the health care provided, the amount of the payment; the amount of the recipient's health insurance or other third-party payments, if any; and the amount that the commission determines the veteran is capable of paying. Payment under this subrule

will be provided directly to the health care provider. The commission shall not pay health care aid under this subrule if the available liquid assets of the veteran are in excess of \$15,000.

d. Applicants for assistance under this subrule will be required to provide the commission with an unpaid bill for service or an estimated cost of service from the health care provider and documentation of the need for the service. For prescription drugs, the applicant must produce documentation of the need for the prescribed drug and documentation stating whether a generic drug is available or appropriate. The commission payment will not exceed an estimated cost of service by a health care provider.

14.4(5) *Expenses relating to the purchase of durable equipment or services to allow a veteran, the veteran's spouse or dependents, or the unremarried spouse of a deceased veteran to remain in their home.*

a. The commission may make reimbursement payments to a veteran or to the unremarried spouse of a deceased veteran for the purchase of durable equipment that allows the veteran, the veteran's spouse or dependents, or the unremarried spouse of a deceased veteran to remain in their home or allows them the ability to utilize more of their home.

b. Individuals requesting reimbursement under this subrule will be required to provide verification of the purchase and installation of the equipment and information relating to the need for the equipment. Individuals may also provide a product and installation cost estimate to the commission for approval, with the understanding that the commission will pay no more than the cost estimate to the supplier or installer. Applicants needing durable equipment as a medical necessity should provide information from a physician.

c. Assistance under this subrule cannot duplicate assistance from other entities, and the maximum amount that may be paid may not exceed \$2,500.

d. The commission shall not pay a reimbursement under this subrule if the available liquid assets of the veteran are in excess of \$15,000.

14.4(6) *Individual counseling or family counseling programs.*

a. The commission may make mental health, substance abuse, and family counseling available to veterans and their families. Individual family members are eligible for counseling.

b. The assistance may include appropriate counseling and treatment programs for veterans and their families in need of services.

c. Any assistance provided under this subrule shall not duplicate other services readily available to veterans and their families. Veterans who are eligible for VA mental health services must initially visit their nearest VA medical facility for initial consultation and continued psychiatric treatment. Payment under this subrule will be made for additional services for the veteran in a location closer to the veteran's home and at a greater frequency than the VA medical center can accommodate.

d. The commission may provide up to \$150 per hour and \$75 per half-hour for outpatient counseling visits to providers who will accept as full payment for the counseling services the amount provided. Counseling and substance abuse services provided in a group setting may be paid up to \$40 per hour. Counseling and substance abuse services may also be provided in an inpatient setting, subject to the maximum amount eligible under 14.4(6) "f."

e. The maximum amount that may be paid under this subrule for any consecutive 12-month period shall not exceed \$5,000. Individuals seeking counseling services are eligible for up to \$2,500, individuals seeking substance abuse treatment and counseling combined are eligible for up to \$3,500, and families seeking counseling services that may also include individual counseling and substance abuse services are eligible for up to \$5,000.

f. The commission may not provide counseling under this subrule unless the aid recipient's counseling service provider agrees to accept, as full payment for the counseling services provided, the amount of the payment; the amount of the recipient's health insurance or other third-party payments, if any; and the amount that the commission determines the veteran is capable of paying. The commission will make payment directly to the entity providing counseling and substance abuse services. The commission shall not pay for counseling under this subrule if the available liquid assets of the veteran are in excess of \$15,000.

14.4(7) *Expenses relating to ambulance and emergency room services for veterans and emergency lodging for immediate family members.*

a. The commission may provide assistance to veterans for expenses related to ambulance trips, including air ambulance transportation, and emergency room visits for emergency care patients or VA health care patients who cannot indicate to emergency personnel that they are to be presented to a VA medical center.

b. Funding through this subrule shall be paid directly to the entity providing the emergency service or transportation after the commission is provided with an unpaid bill. All efforts should be made to utilize all other methods of payment prior to accessing assistance under this subrule.

c. The maximum amount that may be paid under this subrule may not exceed \$7,500.

14.4(8) *Emergency expenses related to vehicle repair, housing repair, or temporary housing assistance.*

a. The commission may provide assistance to a veteran or to the unremarried spouse of a deceased veteran for emergency vehicle repair, emergency housing repair, and temporary housing.

b. Assistance for vehicle repair is limited to expenses that are required for continued use of the vehicle. This assistance will only be granted in cases where the vehicle is needed for travel to and from work-related activities, the applicant is over the age of 65, or substantial hardship will occur if the vehicle is not repaired. Assistance may be provided in situations where the applicant does not have sufficient means to pay an insurance deductible. Assistance may be paid directly to the entity performing the maintenance or the insurance company owed the deductible. In certain circumstances, reimbursement may be made to the veteran or to the unremarried spouse of a deceased veteran in order for the vehicle to be released from the entity providing the service. Assistance will not be provided for damage caused during the commission of a crime, for cosmetic needs, for damage resulting in an auto accident when automobile insurance has not been purchased, or for routine maintenance.

c. Assistance for home repair is limited to repairs that are required to improve the conditions and integrity of the home and are necessary for the safety and security of the residents. Applicants with homeowners insurance may request assistance for payment of a deductible. Assistance may be provided for applicants in disaster situations, home accidents, vandalism, or other situations as determined by the commission. In situations where a home is damaged beyond repair, assistance under this subrule is available to assist the applicant in purchasing a new home.

d. Assistance for transitional housing may be provided to applicants who are displaced from their home during a period of repairs related to a disaster, vandalism, home accident, or other reason that makes staying in the home hazardous to the health of the residents. Any refunded security deposits paid for under this subrule shall be returned to the Iowa veterans trust fund.

e. The maximum amount that may be paid under this subrule for any consecutive 12-month period may not exceed \$2,500 for vehicle repair, \$3,000 for housing repair, and \$1,000 for transitional housing. Lifetime maximum benefit for housing repair and vehicle repair: \$10,000 each.

f. The commission shall not pay a reimbursement under this subrule if the available liquid assets of the veteran are in excess of \$15,000.

14.4(9) *Expenses related to establishing whether a minor child is a dependent of a deceased veteran.*

a. The commission may provide assistance to the family of veterans who are killed while serving on active federal service, for expenses related to paternity or maternity tests or the cost of procuring additional DNA samples from the deceased veteran. This assistance is available to determine whether a child is eligible for United States Department of Veterans Affairs war orphan benefits.

b. Applicants are required to provide the results of the paternity or maternity examinations to the commission upon completion of the tests. Where the deceased veteran is not the parent of the child, the applicant will be required to repay the assistance received as provided in 801—14.6(35A).

c. The maximum amount that may be paid under this subrule is \$2,500.

d. The commission may waive the income threshold for this benefit.

14.4(10) *Family support group programs or programs for children of members of the military.*

a. The commission may award grants to unit family readiness/support groups, family support offices, and other such organizations providing support and programs to families and children of family members.

b. The grant shall be only for projects or programs which are not funded from any other source. The commission shall determine if the applicant's proposed project or program will provide the intended support. In making its determination, the commission shall consider whether the proposed program will provide anticipated favorable results.

c. The maximum amount of aid payable in a consecutive 12-month period under this subrule to a family readiness/support group is \$500.

14.4(11) Honor guard services.

a. The commission may reimburse veterans organizations for providing military funeral honors as follows:

(1) If a single veterans organization provides basic honors, \$25.
(2) If a single veterans organization provides full honors, \$50.
(3) If two or more veterans organizations participate in providing full honors and one of the organizations provides a firing detail, \$50. The organizations may request that the commission split the reimbursement.

(4) If two or more veterans organizations participate in providing basic honors, \$25. Payment shall be to one veterans organization, as determined by the commission.

b. Notwithstanding paragraph 14.4(11) "a," the commission shall not reimburse a veterans organization if federal funding is available to reimburse the veterans organization for providing military funeral honors. The veterans organization shall request reimbursement from federal sources. If a veterans organization receives federal funding for providing military funeral honors at the reimbursement rate of one funeral per day, the department shall reimburse the organization for the provision of military funeral honors at any additional funerals on that day.

c. The maximum amount of aid payable in a calendar year under this subrule to a veterans organization is \$1,000.

d. Veterans service organizations that are not currently providing honor guard services may apply for a \$500 up-front grant for the use of creating a new honor guard within their organization. Applicants must present the commission with an estimated cost for purchasing uniforms and firearms for providing military honors and an estimated number of members who will be available to perform honor guard services. Organizations should also provide information regarding how they plan to pay for additional expenses that may occur outside of trust fund assistance. Applicants will be eligible for reimbursements under paragraphs 14.4(11) "a" to "c" 12 months after the receipt of their original \$500 grant.

14.4(12) Matching funds to veterans service organizations to provide for accredited veteran service officers. Rescinded IAB 11/6/19, effective 12/11/19.

[ARC 7823B, IAB 6/3/09, effective 7/8/09; ARC 0057C, IAB 4/4/12, effective 5/9/12; ARC 2491C, IAB 4/13/16, effective 5/18/16; ARC 4105C, IAB 10/24/18, effective 11/28/18; ARC 4761C, IAB 11/6/19, effective 12/11/19; ARC 5012C, IAB 3/25/20, effective 4/29/20]

801—14.5(35A) Application procedure. Applications for benefits from the veterans trust fund may be obtained at any county veterans affairs office. The county director of veterans affairs shall date-stamp the application and submit it to the Iowa Department of Veterans Affairs, Camp Dodge, Bldg. 3465, 7105 NW 70th Avenue, Johnston, Iowa 50131-1824.

14.5(1) Application process. A person who wishes to apply shall complete an Application for Veterans Trust Fund form and provide such documentation or other evidence as the commission may require in order to determine the awarding or denial of the benefits available under this chapter.

14.5(2) Date of application. The date of the application shall be the date the signed application and written verification are received by the Iowa department of veterans affairs.

14.5(3) Eligibility determination.

a. The county director of veterans affairs or members of the county commission shall make a recommendation to the Iowa commission of veterans affairs as to whether to approve or deny the application. The Iowa commission of veterans affairs or a subcommittee appointed by the chair shall approve or deny all applications. Applications submitted to the Iowa commission of veterans affairs will be processed at its quarterly meetings as set forth in 801—paragraph 1.2(2) "a" or during a conference call for the purpose of voting on a trust fund expenditure. Applications must be approved by

a majority vote of the commission membership or appointed subcommittee. The director of the Iowa department of veterans affairs shall notify an applicant within 15 days of the commission's decision. An explanation of the reasons for rejection of an application will accompany denials.

b. Applications for honor guard reimbursements under subrule 14.4(11) shall be processed solely by the Iowa department of veterans affairs and do not need commission approval for expenditure of trust fund interest balance funds for this purpose.

14.5(4) *Waiting list.* After all veterans trust fund moneys have been obligated, the commission shall approve or deny pending applications based on eligibility. Applicants who meet the eligibility requirements and are approved for payment by the commission shall be placed on a waiting list based on the date of approval and then according to the order in which the completed applications and verification were received by the Iowa commission of veterans affairs. In the event that more than one application is received at one time, the applicant shall be entered on the waiting list on the basis of the applicant's birthday, the oldest applicant being first on the waiting list.

[ARC 7823B, IAB 6/3/09, effective 7/8/09; ARC 3341C, IAB 9/27/17, effective 11/1/17]

801—14.6(35A) Recovery of erroneous payments.

14.6(1) *Erroneous payments.* The commission may recover payments made as a grant under this chapter if any of the following apply:

- a.* The information provided by the applicant is inaccurate.
- b.* The commission incorrectly calculated the grant amount.
- c.* The applicant is not entitled to a grant or is entitled to a lower grant amount as a result of a change in circumstances that affects the applicant's eligibility to receive the grant.

14.6(2) *Amount of recovery.* The commission may recover only the portion of the grant to which the applicant would not have been entitled if the correct information had been provided or if the grant had been properly calculated or as a change in circumstances warrants.

14.6(3) *Remedies.* The commission may request repayment of the amount due under subrule 14.6(2). In lieu of a lump sum payment, the commission may enter into an agreement under which the applicant may repay the amount due within a 12-month period. If the applicant fails to repay the amount due within 30 days of a request for repayment or fails to comply with the terms of a repayment agreement, the commission may offset future grants that the applicant may be entitled to under this chapter until the amount due has been recovered. The commission may also suspend other benefits available to the applicant until the amount due has been recovered.

14.6(4) *Waiver.* The commission may temporarily or permanently waive its authority to recover payments under subrule 14.6(1) or suspend benefits under subrule 14.6(3) if the applicant's household income is totally exempt from Iowa garnishment law.

14.6(5) *Appeal.* Any commission decision under this chapter is subject to appeal under rule 801—14.7(35A).

801—14.7(35A) Appeal rights.

14.7(1) *Subcommittee action.* An applicant may appeal the decision of the subcommittee to the full Iowa commission of veterans affairs. The applicant shall appeal the decision of the subcommittee to the commission in writing within 30 days of receiving the written denial and shall provide relevant new information to substantiate the appeal.

14.7(2) *Final agency action.* The approval or denial of an application by the commission or by the department shall be the final decision of the agency.

14.7(3) *Judicial review.* Judicial review of the commission's or department's final decisions may be sought in accordance with Iowa Code section 17A.19.

[ARC 7823B, IAB 6/3/09, effective 7/8/09]

These rules are intended to implement Iowa Code section 35A.13 as amended by 2007 Iowa Acts, House File 817, section 7.

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CHAPTER 10
GENERAL INDUSTRY SAFETY AND HEALTH RULES

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/7/98, see 347—Ch 10]

875—10.1(88) Definitions. As used in these rules, unless the context clearly requires otherwise:

“*Part*” means 875—Chapter 10, Iowa Administrative Code.

“*Standard*” means a standard which requires conditions, or the adoption or use of one or more practices, means, methods, operations, or processes, reasonably necessary or appropriate to provide safe or healthful employment and places of employment.

875—10.2(88) Applicability of standards.

10.2(1) None of the standards in this chapter shall apply to working conditions of employees with respect to which federal agencies other than the United States Department of Labor, exercise statutory authority to prescribe or enforce standards or regulations affecting occupational safety or health.

10.2(2) If a particular standard is specifically applicable to a condition, practice, means, method, operation, or process, it shall prevail over any different general standard which might otherwise be applicable to the same condition, practice, means, method, operation, or process.

10.2(3) However, any standard shall apply according to its terms to any employment and place of employment in any industry, even though particular standards are also prescribed for the industry, as in 1910.12, 1910.261, 1910.262, 1910.263, 1910.264, 1910.265, 1910.266, 1910.267, and 1910.268 of 29 CFR 1910, to the extent that none of such particular standards applies.

10.2(4) In the event a standard protects on its face a class of persons larger than employees, the standard shall be applicable under this part only to employees and their employment and places of employment.

10.2(5) An employer who is in compliance with any standard in this part shall be deemed to be in compliance with the requirement of Iowa Code section 88.4, but only to the extent of the condition, practice, means, method, operation or process covered by the standard.

875—10.3(88) Incorporation by reference. The standards of agencies of the U.S. Government, and organizations which are not agencies of the U.S. Government which are incorporated by reference in this chapter have the same force and effect as other standards in this chapter. Only mandatory provisions (i.e., provisions containing the word “shall” or other mandatory language) of standards incorporated by reference are adopted under the Act.

875—10.4(88) Exception for hexavalent chromium exposure in metal and surface finishing job shops. Prior to December 31, 2008, for employers that comply with the requirements of this rule, the labor commissioner shall enforce respiratory protection provisions only with respect to employees who fall into one of the six categories outlined in Paragraph 4, Appendix A, 29 CFR 1910.1026, except that the phrase “Exhibit B to this Agreement” shall refer to Exhibit B, Appendix A, 29 CFR 1910.1026. This exception is limited to the narrow circumstances outlined below and shall expire on May 31, 2010.

10.4(1) Eligibility. An employer’s facility is eligible for this exception if the employer is a member of the Surface Finishing Industry Council or the facility is a surface-finishing or metal-finishing job shop that sells plating or anodizing services to other companies.

10.4(2) Participation. To be covered by this exception, eligible employers must complete and submit a Declaration of Participation via mail to the Labor Commissioner, 1000 East Grand Avenue, Des Moines, Iowa 50319, or via facsimile to (515)281-7995. Declarations of Participation must be postmarked or received on or before April 7, 2007. Each declaration shall apply only to one facility. Declaration of Participation forms are available at www.iowaworkforce.org/labor/iosh/index.html or by calling (515)242-5870.

10.4(3) Applicability. This exception applies only to surface- and metal-finishing operations within covered facilities.

10.4(4) Feasible engineering controls. Participating employers must implement feasible engineering controls necessary to reduce hexavalent chromium levels at their facilities to or below five micrograms per cubic meter of air calculated as an eight-hour, time-weighted average by December 31, 2008. In fulfilling this obligation, participating employers may select from the engineering and work practice controls listed in Exhibit A, Appendix A, 29 CFR 1910.1026, or may adopt other controls.

10.4(5) Employee training. Participating employers shall train their employees in accordance with the provisions of 29 CFR 1910.1026(l)(2). Using language the employees can understand, participating employers will also train their employees on the provisions of this exception no later than June 7, 2007.

10.4(6) Compliance and monitoring. Participating employers shall comply with the requirements set forth in Paragraphs 3 and 4, Appendix A, 29 CFR 1910.1026, except that as used in Appendix A:

- a. The acronym “OSHA” shall refer to the labor commissioner;
- b. The word “Company” shall refer to employers participating in this exception;
- c. The word “Agreement” shall refer to this rule; and
- d. The phrase “Exhibit B to this Agreement” shall refer to Exhibit B, Appendix A, 29 CFR 1910.1026.

875—10.5 and 10.6 Reserved.

875—10.7(88) Definitions and requirements for a nationally recognized testing laboratory. The federal regulations adopted at 29 CFR, Chapter XVII, Part 1910, regulation 1910.7 and Appendix A, as published at 53 Fed. Reg. 12120 (April 12, 1988) and amended at 53 Fed. Reg. 16838 (May 11, 1988), 54 Fed. Reg. 24333 (June 7, 1989) and 65 Fed. Reg. 46818 (July 31, 2000) are adopted by reference.

875—10.8 to 10.11 Reserved.

875—10.12(88) Construction work.

10.12(1) Standards. The standards prescribed in 875—Chapter 26 are adopted as occupational safety and health standards and shall apply, according to the provisions thereof, to every employment and place of employment of every employee engaged in construction work. Each employer shall protect the employment and places of employment of each employee engaged in construction work by complying with the provisions of 875—Chapter 26.

10.12(2) Definition. For the purpose of this rule, “*construction work*” means work for construction, alteration, or repair including painting and redecorating, and where applicable, the erection of new electrical transmission and distribution lines and equipment, and the alteration, conversion, and improvement of the existing transmission and distribution lines and equipment. This incorporation by reference of 875—Chapter 26 (Part 1926) is not intended to include references to interpretative rules having relevance to the application of the construction safety Act, but having no relevance to the application of Iowa Code chapter 88.

875—10.13 to 10.18 Reserved.

875—10.19(88) Special provisions for air contaminants.

10.19(1) Asbestos, tremolite, anthophyllite, and actinolite dust. Reserved.

10.19(2) Vinyl chloride. Rule 1910.1017 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to vinyl chloride in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to vinyl chloride which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(3) Acrylonitrile. Rule 1910.1045 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to acrylonitrile in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to acrylonitrile which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(4) Inorganic arsenic. Rule 1910.1018 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to inorganic arsenic in every employment

and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to inorganic arsenic which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(5) Rescinded, effective 6/10/87.

10.19(6) *Lead*. Rescinded IAB 8/5/92, effective 8/5/92.

10.19(7) *Ethylene oxide*. Rule 1910.1047 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to ethylene oxide in every employment and place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to ethylene oxide which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(8) *Benzene*. Rule 1910.1028 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to benzene in every place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to benzene which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(9) *Formaldehyde*. Rule 1910.1048 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to formaldehyde in every place of employment covered by 875—10.12(88), in lieu of any different standard on exposure to formaldehyde which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

10.19(10) *Methylene chloride*. Rule 1910.1052 of the federal rules as adopted by reference in 875—10.20(88) shall apply to the exposure of every employee to methylene chloride in every employment and place of employment covered by 875—10.12(88) in lieu of any different standard on exposure to methylene chloride which would otherwise be applicable by virtue of any rule adopted in 875—Chapter 26.

875—10.20(88) Adoption by reference. The rules beginning at 1910.20 and continuing through 1910, as adopted by the United States Secretary of Labor shall be the rules for implementing Iowa Code chapter 88. This rule adopts the Federal Occupational Safety and Health Standards of 29 CFR, Chapter XVII, Part 1910 as published at 37 Fed. Reg. 22102 to 22324 (October 18, 1972) and as amended at:

37 Fed. Reg. 23719 (November 8, 1972)
37 Fed. Reg. 24749 (November 21, 1972)
38 Fed. Reg. 3599 (February 8, 1973)
38 Fed. Reg. 9079 (April 10, 1973)
38 Fed. Reg. 10932 (May 3, 1973)
38 Fed. Reg. 14373 (June 1, 1973)
38 Fed. Reg. 16223 (June 21, 1973)
38 Fed. Reg. 19030 (July 17, 1973)
38 Fed. Reg. 27048 (September 28, 1973)
38 Fed. Reg. 28035 (October 11, 1973)
38 Fed. Reg. 33397 (December 4, 1973)
39 Fed. Reg. 1437 (January 9, 1974)
39 Fed. Reg. 3760 (January 29, 1974)
39 Fed. Reg. 6110 (February 19, 1974)
39 Fed. Reg. 9958 (March 15, 1974)
39 Fed. Reg. 19468 (June 3, 1974)
39 Fed. Reg. 35896 (October 4, 1974)
39 Fed. Reg. 41846 (December 3, 1974)
39 Fed. Reg. 41848 (December 3, 1974)
40 Fed. Reg. 3982 (January 27, 1975)
40 Fed. Reg. 13439 (March 26, 1975)
40 Fed. Reg. 18446 (April 28, 1975)
40 Fed. Reg. 23072 (May 28, 1975)
40 Fed. Reg. 23743 (June 2, 1975)
40 Fed. Reg. 24522 (June 9, 1975)

40 Fed. Reg. 27369 (June 27, 1975)
40 Fed. Reg. 31598 (July 28, 1975)
41 Fed. Reg. 11504 (March 19, 1976)
41 Fed. Reg. 13352 (March 30, 1976)
41 Fed. Reg. 35184 (August 20, 1976)
41 Fed. Reg. 46784 (October 22, 1976)
41 Fed. Reg. 55703 (December 21, 1976)
42 Fed. Reg. 2956 (January 14, 1977)
42 Fed. Reg. 3304 (January 18, 1977)
42 Fed. Reg. 45544 (September 9, 1977)
42 Fed. Reg. 46540 (September 16, 1977)
42 Fed. Reg. 37668 (July 22, 1977)
43 Fed. Reg. 11527 (March 17, 1978)
43 Fed. Reg. 19624 (May 5, 1978)
43 Fed. Reg. 27394 (June 23, 1978)
43 Fed. Reg. 27434 (June 23, 1978)
43 Fed. Reg. 28472 (June 30, 1978)
43 Fed. Reg. 28473 (June 30, 1978)
43 Fed. Reg. 31330 (July 21, 1978)
43 Fed. Reg. 35032 (August 8, 1978)
43 Fed. Reg. 45809 (October 3, 1978)
43 Fed. Reg. 49744 (October 24, 1978)
43 Fed. Reg. 51759 (November 7, 1978)
43 Fed. Reg. 53007 (November 14, 1978)
43 Fed. Reg. 56893 (December 5, 1978)
43 Fed. Reg. 57602 (December 8, 1978)
44 Fed. Reg. 5447 (January 26, 1979)
44 Fed. Reg. 50338 (August 28, 1979)
44 Fed. Reg. 60981 (October 23, 1979)
44 Fed. Reg. 68827 (November 30, 1979)
45 Fed. Reg. 6713 (January 29, 1980)
45 Fed. Reg. 8594 (February 8, 1980)
45 Fed. Reg. 12417 (February 26, 1980)
45 Fed. Reg. 35277 (May 23, 1980)
45 Fed. Reg. 41634 (June 20, 1980)
45 Fed. Reg. 54333 (August 15, 1980)
45 Fed. Reg. 60703 (September 12, 1980)
46 Fed. Reg. 4056 (January 16, 1981)
46 Fed. Reg. 6288 (January 21, 1981)
46 Fed. Reg. 24557 (May 1, 1981)
46 Fed. Reg. 32022 (June 19, 1981)
46 Fed. Reg. 40185 (August 7, 1981)
46 Fed. Reg. 2632 (August 21, 1981)
46 Fed. Reg. 42632 (August 21, 1981)
46 Fed. Reg. 45333 (September 11, 1981)
46 Fed. Reg. 60775 (December 11, 1981)
47 Fed. Reg. 39161 (September 7, 1982)
47 Fed. Reg. 51117 (November 12, 1982)
47 Fed. Reg. 53365 (November 26, 1982)
48 Fed. Reg. 2768 (January 21, 1983)
48 Fed. Reg. 9641 (March 8, 1983)
48 Fed. Reg. 9776 (March 8, 1983)

48 Fed. Reg. 29687 (June 28, 1983)
49 Fed. Reg. 881 (January 6, 1984)
49 Fed. Reg. 4350 (February 3, 1984)
49 Fed. Reg. 5321 (February 10, 1984)
49 Fed. Reg. 25796 (June 22, 1984)
50 Fed. Reg. 1050 (January 9, 1985)
50 Fed. Reg. 4648 (February 1, 1985)
50 Fed. Reg. 9800 (March 12, 1985)
50 Fed. Reg. 36992 (September 11, 1985)
50 Fed. Reg. 37353 (September 13, 1985)
50 Fed. Reg. 41494 (October 11, 1985)
50 Fed. Reg. 51173 (December 13, 1985)
51 Fed. Reg. 22733 (June 20, 1986)
51 Fed. Reg. 24325 (July 3, 1986)
51 Fed. Reg. 25053 (July 10, 1986)
51 Fed. Reg. 33033 (September 18, 1986)
51 Fed. Reg. 33260 (September 19, 1986)
51 Fed. Reg. 34560 (September 29, 1986)
51 Fed. Reg. 45663 (December 19, 1986)
52 Fed. Reg. 16241 (May 4, 1987)
52 Fed. Reg. 17753 (May 12, 1987)
52 Fed. Reg. 34562 (September 11, 1987)
52 Fed. Reg. 36026 (September 25, 1987)
52 Fed. Reg. 36387 (September 28, 1987)
52 Fed. Reg. 46291 (December 4, 1987)
52 Fed. Reg. 49624 (December 31, 1987)
53 Fed. Reg. 6629 (March 2, 1988)
53 Fed. Reg. 8352 (March 14, 1988)
53 Fed. Reg. 11436 (April 6, 1988)
53 Fed. Reg. 12120 (April 12, 1988)
53 Fed. Reg. 16838 (May 11, 1988)
53 Fed. Reg. 17695 (May 18, 1988)
53 Fed. Reg. 27346 (July 20, 1988)
53 Fed. Reg. 27960 (July 26, 1988)
53 Fed. Reg. 34736 (September 8, 1988)
53 Fed. Reg. 35625 (September 14, 1988)
53 Fed. Reg. 37080 (September 23, 1988)
53 Fed. Reg. 38162 (September 29, 1988)
53 Fed. Reg. 39581 (October 7, 1988)
53 Fed. Reg. 45080 (November 8, 1988)
53 Fed. Reg. 47188 (November 22, 1988)
53 Fed. Reg. 49981 (December 13, 1988)
54 Fed. Reg. 2920 (January 19, 1989)
54 Fed. Reg. 6888 (February 15, 1989)
54 Fed. Reg. 9317 (March 6, 1989)
54 Fed. Reg. 12792 (March 28, 1989)
54 Fed. Reg. 28054 (July 5, 1989)
54 Fed. Reg. 29274 (July 11, 1989)
54 Fed. Reg. 29545 (July 13, 1989)
54 Fed. Reg. 30704 (July 21, 1989)
54 Fed. Reg. 31456 (July 28, 1989)
54 Fed. Reg. 31765 (August 1, 1989)

54 Fed. Reg. 36687 (September 1, 1989)
54 Fed. Reg. 36767 (September 5, 1989)
54 Fed. Reg. 37531 (September 11, 1989)
54 Fed. Reg. 41364 (October 6, 1989)
54 Fed. Reg. 46610 (November 6, 1989)
54 Fed. Reg. 47513 (November 15, 1989)
54 Fed. Reg. 49971 (December 4, 1989)
54 Fed. Reg. 50372 (December 6, 1989)
54 Fed. Reg. 52024 (December 20, 1989)
55 Fed. Reg. 3146 (January 30, 1990)
55 Fed. Reg. 3300 (January 31, 1990)
55 Fed. Reg. 3723 (February 5, 1990)
55 Fed. Reg. 4998 (February 13, 1990)
55 Fed. Reg. 7967 (March 6, 1990)
55 Fed. Reg. 12110 (March 30, 1990)
55 Fed. Reg. 12819 (April 6, 1990)
55 Fed. Reg. 13696 (April 11, 1990)
55 Fed. Reg. 14073 (April 13, 1990)
55 Fed. Reg. 19259 (May 9, 1990)
55 Fed. Reg. 25094 (June 10, 1990)
55 Fed. Reg. 26431 (June 28, 1990)
55 Fed. Reg. 32014 (August 6, 1990)
55 Fed. Reg. 38677 (September 20, 1990)
55 Fed. Reg. 46053 (November 1, 1990)
55 Fed. Reg. 46949 (November 8, 1990)
55 Fed. Reg. 50686 (December 10, 1990)
56 Fed. Reg. 15832 (April 18, 1991)
56 Fed. Reg. 24686 (May 31, 1991)
56 Fed. Reg. 43700 (September 4, 1991)
56 Fed. Reg. 64175 (December 6, 1991)
57 Fed. Reg. 6403 (February 24, 1992)
57 Fed. Reg. 7847 (March 4, 1992)
57 Fed. Reg. 7878 (March 5, 1992)
57 Fed. Reg. 22307 (May 27, 1992)
57 Fed. Reg. 24330 (June 8, 1992)
57 Fed. Reg. 24701 (June 10, 1992)
57 Fed. Reg. 27160 (June 18, 1992)
57 Fed. Reg. 29204 (July 1, 1992)
57 Fed. Reg. 29206 (July 1, 1992)
57 Fed. Reg. 35666 (August 10, 1992)
57 Fed. Reg. 42388 (September 14, 1992)
58 Fed. Reg. 4549 (January 14, 1993)
58 Fed. Reg. 15089 (March 19, 1993)
58 Fed. Reg. 16496 (March 29, 1993)
58 Fed. Reg. 21778 (April 23, 1993)
58 Fed. Reg. 34845 (June 29, 1993)
58 Fed. Reg. 35308 (June 30, 1993)
58 Fed. Reg. 35340 (June 30, 1993)
58 Fed. Reg. 40191 (July 27, 1993)
59 Fed. Reg. 4435 (January 31, 1994)
59 Fed. Reg. 6169 (February 9, 1994)
59 Fed. Reg. 16360 (April 6, 1994)

59 Fed. Reg. 26115 (May 19, 1994)
59 Fed. Reg. 33661 (June 30, 1994)
59 Fed. Reg. 33910 (July 1, 1994)
59 Fed. Reg. 36699 (July 19, 1994)
59 Fed. Reg. 40729 (August 9, 1994)
59 Fed. Reg. 41057 (August 10, 1994)
59 Fed. Reg. 43270 (August 22, 1994)
59 Fed. Reg. 51741 (October 12, 1994)
59 Fed. Reg. 65948 (December 22, 1994)
60 Fed. Reg. 9624 (February 21, 1995)
60 Fed. Reg. 11194 (March 1, 1995)
60 Fed. Reg. 33344 (June 28, 1995)
60 Fed. Reg. 33984 (June 29, 1995)
60 Fed. Reg. 47035 (September 8, 1995)
60 Fed. Reg. 52859 (October 11, 1995)
61 Fed. Reg. 5508 (February 13, 1996)
61 Fed. Reg. 9230 (March 7, 1996)
61 Fed. Reg. 9583 (March 8, 1996)
61 Fed. Reg. 19548 (May 2, 1996)
61 Fed. Reg. 21228 (May 9, 1996)
61 Fed. Reg. 31430 (June 20, 1996)
61 Fed. Reg. 43456 (August 23, 1996)
61 Fed. Reg. 56831 (November 4, 1996)
62 Fed. Reg. 1600 (January 10, 1997)
62 Fed. Reg. 29668 (June 2, 1997)
62 Fed. Reg. 40195 (July 25, 1997)
62 Fed. Reg. 42018 (August 4, 1997)
62 Fed. Reg. 42666 (August 8, 1997)
62 Fed. Reg. 43581 (August 14, 1997)
62 Fed. Reg. 48175 (September 15, 1997)
62 Fed. Reg. 54383 (October 20, 1997)
62 Fed. Reg. 65203 (December 11, 1997)
62 Fed. Reg. 66276 (December 18, 1997)
63 Fed. Reg. 1269 (January 8, 1998)
63 Fed. Reg. 13339 (March 19, 1998)
63 Fed. Reg. 17093 (April 8, 1998)
63 Fed. Reg. 20098 (April 23, 1998)
63 Fed. Reg. 33467 (June 18, 1998)
63 Fed. Reg. 50729 (September 22, 1998)
63 Fed. Reg. 66038 (December 1, 1998)
63 Fed. Reg. 66270 (December 1, 1998)
64 Fed. Reg. 13700 (March 22, 1999)
64 Fed. Reg. 13908 (March 23, 1999)
64 Fed. Reg. 22552 (April 27, 1999)
65 Fed. Reg. 76567 (December 7, 2000)
66 Fed. Reg. 5324 (January 18, 2001)
66 Fed. Reg. 18191 (April 6, 2001)
67 Fed. Reg. 67961 (November 7, 2002)
68 Fed. Reg. 75780 (December 31, 2003)
69 Fed. Reg. 7363 (February 17, 2004)
69 Fed. Reg. 31881 (June 8, 2004)
69 Fed. Reg. 46993 (August 4, 2004)

70 Fed. Reg. 53929 (September 13, 2005)
 70 Fed. Reg. 1140 (January 5, 2005)
 71 Fed. Reg. 10373 (February 28, 2006)
 71 Fed. Reg. 36008 (June 23, 2006)
 71 Fed. Reg. 63242 (October 30, 2006)
 72 Fed. Reg. 7190 (February 14, 2007)
 72 Fed. Reg. 64428 (November 15, 2007)
 72 Fed. Reg. 71068 (December 14, 2007)
 73 Fed. Reg. 75583 (December 12, 2008)
 68 Fed. Reg. 32638 (June 2, 2003)
 74 Fed. Reg. 46355 (September 9, 2009)
 74 Fed. Reg. 40447 (August 11, 2009)
 75 Fed. Reg. 12685 (March 17, 2010)
 76 Fed. Reg. 33606 (June 8, 2011)
 76 Fed. Reg. 75786 (December 5, 2011)
 77 Fed. Reg. 17764 (March 26, 2012)
 76 Fed. Reg. 80738 (December 27, 2011)
 77 Fed. Reg. 37598 (June 22, 2012)
 77 Fed. Reg. 46949 (August 7, 2012)
 78 Fed. Reg. 9313 (February 8, 2013)
 78 Fed. Reg. 69549 (November 20, 2013)
 79 Fed. Reg. 20629 (April 11, 2014)
 79 Fed. Reg. 56960 (September 24, 2014)
 80 Fed. Reg. 60036 (October 5, 2015)
 81 Fed. Reg. 16090 (March 25, 2016)
 81 Fed. Reg. 16861 (March 25, 2016)
 81 Fed. Reg. 82981 (November 18, 2016)
 82 Fed. Reg. 2735 (January 9, 2017)
 83 Fed. Reg. 19948 (May 7, 2018)
 84 Fed. Reg. 21457 (May 14, 2019)
 84 Fed. Reg. 50755 (September 26, 2019)
 84 Fed. Reg. 68795 (December 17, 2019)

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