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

In addition to the changes adopted by agencies, the replacement chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

Human Services Department[441]

Replace Chapter 79
Replace Chapter 83
Replace Chapter 110

Inspections and Appeals Department[481]

Replace Chapters 57 to 59
Replace Chapters 62 and 63
Replace Chapter 65

Iowa Public Employees' Retirement System[495]

Replace Chapters 4 to 6
Replace Chapters 11 to 13
Replace Chapters 15 and 16

Public Health Department[641]

Replace Analysis
Replace Chapter 4

Transportation Department[761]

Replace Chapter 4
Replace Chapter 520
Replace Chapter 600
Replace Chapter 605

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE
[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Fee for service with cost settlement. Providers of case management services shall be reimbursed on the basis of a payment rate for a 15-minute unit of service based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected unit rate for each participating provider. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles).

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider

during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

1. The indirect administrative costs shall be limited to 20 percent of other costs.
2. Mileage shall be reimbursed at a rate no greater than the state employee rate.
3. The rates a provider may charge are subject to limits established at 79.1(2).
4. Costs of operation shall include only those costs that pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) “e”(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider’s reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to 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 service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) Basis of reimbursement of specific provider categories.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 11/30/09 less 5%. Air ambulance: Fee schedule in effect 11/30/09 less 5%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	\$50.57 per day for each day on which a team meeting is held. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/11.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 11/30/09 less 5%.
Family planning clinics	Fee schedule	Fee schedule in effect 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
HCBS waiver service providers, including:		<p>3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.</p> <p>Except as noted, limits apply to all waivers that cover the named provider.</p>
1. Adult day care	Fee schedule	<p>For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers effective 1/1/13: Provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: Veterans Administration contract rate or \$22.56 per half-day, \$44.91 per full day, or \$67.35 per extended day if no Veterans Administration contract.</p> <p>For intellectual disability waiver: County contract rate or, effective 1/1/13 in the absence of a contract rate, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate, \$30.06 per half-day, \$60.00 per full day, or \$76.50 per extended day.</p>
2. Emergency response system:		
Personal response system	Fee schedule	<p>Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: Initial one-time fee: \$50.52. Ongoing monthly fee: \$39.29.</p>
Portable locator system	Fee schedule	<p>Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: One equipment purchase: \$313.84. Initial one-time fee: \$50.52. Ongoing monthly fee: \$39.29.</p>
3. Home health aides	Retrospective cost-related	<p>For AIDS/HIV, elderly, and ill and handicapped waivers effective 1/1/13: Lesser of maximum Medicare rate in effect 11/30/09 plus 2% or maximum Medicaid rate in effect 6/30/12 plus 2%.</p> <p>For intellectual disability waiver effective 1/1/13: Lesser of maximum Medicare rate in effect 11/30/09 plus 2% or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly rate.</p>
4. Homemakers	Fee schedule	<p>Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$20.21 per hour.</p>

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$84.58 per visit. For intellectual disability waiver effective 1/1/13: Lesser of maximum Medicare rate in effect 11/30/09 plus 2% or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly rate.
6. Respite care when provided by:	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$84.58 per visit.
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: Lesser of maximum Medicare rate in effect 11/30/09 plus 2% or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly rate, not to exceed \$302.88 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: Lesser of maximum Medicare rate in effect 11/30/09 plus 2% or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly rate, not to exceed \$302.88 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour not to exceed \$302.88 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$34.43 per hour not to exceed \$302.88 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$18.37 per hour not to exceed \$302.88 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour not to exceed \$302.88 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$34.43 per hour not to exceed \$302.88 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$18.37 per hour not to exceed \$302.88 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour not to exceed \$302.88 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour not to exceed the facility's daily Medicaid rate.
Camps	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour not to exceed \$302.88 per day.
Adult day care	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour not to exceed contractual daily rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
7. Chore service	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$7.86 per half hour.
8. Home-delivered meals	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$7.86 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 1/1/13: \$1,030.20 lifetime maximum. For intellectual disability waiver effective 1/1/13: \$5,151 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers effective 1/1/13: \$6,181.20 per year.
10. Mental health outreach providers	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 1/1/13: County contract rate or, in the absence of a contract rate, provider's rate in effect 6/30/12 plus 2%.
12. Nutritional counseling	Fee schedule	Effective 1/1/13 for non-county contract: Provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$8.42 per unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 1/1/13: \$112.25 per unit.
14. Senior companion	Fee schedule	Effective 1/1/13 for non-county contract: Provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$6.72 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$20.60 per hour not to exceed \$119.05 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$1,139.34 per calendar month. When prorated per day for a partial month, \$37.44 per day.
Individual	Fee agreed upon by member and provider	Effective 1/1/13, \$13.74 per hour not to exceed \$80.13 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
16. Counseling		
Individual:	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$11.01 per unit.
Group:	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$44.00 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1) "d."	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13: \$35.68 per hour not to exceed the maximum daily ICF/ID rate in effect 6/30/12 plus 2%.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$927.18 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$927.18 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13: \$35.68 per hour. Maximum of 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13: \$35.68 per hour for all activities other than personal care and services in an enclave setting. \$20.21 per hour for personal care. \$6.31 per hour for services in an enclave setting. \$2,941.38 per month for total service. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 1/1/13, \$6,181.20 per year.
21. Behavioral programming	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$11.01 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$44.00 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
23. Prevocational services	Fee schedule	County contract rate or, in absence of a contract rate, effective 1/1/13: Lesser of provider's rate in effect 6/30/12 plus 2%, \$49.18 per day, \$24.59 per half-day, or \$13.47 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 1/1/13: Lesser of maximum Medicare rate in effect 11/30/09 plus 2% or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 1/1/13: Lesser of maximum Medicare rate in effect 11/30/09 plus 2% or maximum Medicaid rate in effect 6/30/12 plus 2%, converted to an hourly rate.
Child development home or center	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.38 per hour.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$35.68 per hour, not to exceed the maximum ICF/ID rate per day in effect 6/30/12 plus 2%.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13: Not to exceed the maximum ICF/ID rate per day in effect 6/30/12 plus 2%.
26. Day habilitation	Fee schedule	Effective 1/1/13: County contract rate or, in the absence of a contract rate, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$13.47 per hour, \$32.79 per half-day, or \$65.58 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 1/1/13, \$6,181.20 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$35.68 per hour.
29. In-home family therapy	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$95.50 per hour.
30. Financial management services	Fee schedule	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$66.96 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 1/1/13, provider's rate in effect 6/30/12 plus 2%. If no 6/30/12 rate: \$15.45 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.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider.	\$25.00 per day.
Health home services provider	Fee schedule based on number of member's chronic conditions (not including conditions for which member is only at risk). Submission of the per-member per-month (PMPM) claim from the provider confirms that health home services are being provided.	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1) "d."	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	\$46.70 per hour not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	\$13.21 per hour, \$32.15 per half-day, or \$64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	\$9.91 per hour, \$24.11 per half-day, or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of \$34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	\$6.19 per hour for services in an enclave setting; \$19.81 per hour for personal care; and \$34.98 per hour for all other services. Total not to exceed \$2,883.71 per month. Maximum of 40 units per week.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 6/30/12 or maximum Medicaid rate in effect 6/30/12 plus 2%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost-related settlement	Medicaid rate in effect 6/30/12 plus 2%.
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 11/30/09 less 5%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16) "c"	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members. 2. Fee schedule for service provided for all other Medicaid members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 11/30/09 less 5%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
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 non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(3) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Occupational therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 11/30/09 less 5%.
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7) "a"	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/12 less 2%.
Qualified primary care services furnished in 2013 or 2014	See 79.1(7) "c"	Rate provided by 79.1(7) "c"
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children		
1. Inpatient	Retrospective cost-related	Effective 8/1/11: Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa.
2. Outpatient day treatment	Fee schedule	Effective 8/1/11: Fee schedule in effect 11/30/09.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Public health agencies	Fee schedule	Fee schedule rate.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 11/30/09 less 5%.
Speech-language pathologists	Fee schedule	Medicare fee schedule.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)“d.”	Retrospective cost-settled rate.

79.1(3) Ambulatory surgical centers.

a. Payment is made for facility services on a fee schedule determined by the department and published on the department’s Web site. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)“c”). This payment is made directly to the physician or dentist.

79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers. Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) Reimbursement for hospitals.

a. Definitions.

“Adolescent” shall mean a Medicaid patient 17 years or younger.

“Adult” shall mean a Medicaid patient 18 years or older.

“Average daily rate” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

“Base year cost report” means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5)“x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“Blended base amount” shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year

cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" shall mean an add-on to the blended base amount, which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5) "f," so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

“Direct medical education costs” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital’s case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share payment” shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

“Disproportionate share percentage” shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital’s own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5) “y”(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share rate” shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

“DRG weight” shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

“Final payment rate” shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider’s reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

“Full DRG transfer” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse

qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

“Indirect medical education rate” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Inlier” shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

“Long stay outlier” shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)“f.”

“Low-income utilization rate” shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Medicaid inpatient utilization rate” shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Neonatal intensive care unit” shall mean a designated level II or level III neonatal unit.

“Net discharges” shall mean total discharges minus transfers and short stay outliers.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“Rate table listing” shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

“*Rebasing*” shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

“*Rebasing implementation year*” means 2008 and every three years thereafter.

“*Recalibration*” shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

“*Short stay day outlier*” shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)“*f*.”

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)“*r*.” Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)“*r*.” Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital’s trimmed claims that match the hospital’s base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital

for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two.

Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is

through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5)“r,” both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)“r,” and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within seven days for same condition. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within seven 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.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)“r,” and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)“r,” which are paid per diem, as specified in paragraph 79.1(5)“i.”

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)“r” and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)“r” is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital’s base-year cost report pursuant to paragraph 79.1(5)“a.” No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)“j.”

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state’s fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)“y”(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted

blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph "y."

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph 79.1(5)"y." 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 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 \$8,210,006. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. 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 \$14,415,396. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost

report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

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 \$6,890,959. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5) "u" or 79.1(5) "v" cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.
2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.
3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5) "a" to "z" are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5) "a" to "z." Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as

submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5) “k.”

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.

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. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following:

- (1) Hospital inpatient unit (POS 21).
- (2) Hospital outpatient unit (POS 22).
- (3) Hospital emergency room (POS 23).
- (4) Ambulatory surgical center (POS 24).
- (5) Skilled nursing facility (POS 31).
- (6) Inpatient psychiatric facility (POS 51).
- (7) Community mental health center (POS 53).
- (8) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services furnished in 2013 or 2014. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar years 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 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.

(4) Primary care services 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) 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 years 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).

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to May 16, 2012. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)“c,” whichever is later, reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8) "i"; or

2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8) "i."

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph 79.1(8) "i."

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph 79.1(8) "i."

(4) The submitted charge, representing the provider's usual and customary charge for the drug.

b. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8) "d," whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined:

1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8) "i"; or

2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8) "i."

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

c. Effective February 1, 2013, or upon federal approval, whichever is later, 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 actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8) "k," plus the professional dispensing fee determined pursuant to paragraph 79.1(8) "j."

(2) The maximum allowable cost (MAC), defined as the specific upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee determined pursuant to paragraph 79.1(8) "j."

(3) The submitted charge, representing the provider's usual and customary charge for the drug.

d. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8) "g," plus the professional dispensing fee determined pursuant to paragraph 79.1(8) "j."

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

e. No payment shall be made for sales tax.

f. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

g. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8) "c," whichever is later, the basis of payment for nonprescription drugs shall be the same as specified in paragraph 79.1(8) "a" except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

h. An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

i. For services rendered on or after August 1, 2011, and before February 1, 2013, or federal approval of the professional dispensing fee provided in paragraph 79.1(8) “*j*,” whichever is later, the professional dispensing fee is \$6.20 or the pharmacy’s usual and customary fee, whichever is lower.

j. Effective February 1, 2013, or upon federal approval, whichever is later, professional dispensing fees shall be amounts determined by the department based on a survey of Iowa Medicaid retail pharmacy providers’ costs of dispensing drugs to Medicaid beneficiaries. For services rendered on or after February 1, 2013, and after federal approval, the dispensing fee for all drugs shall be \$10.02.

k. For purposes of this rule, average actual acquisition cost (AAC) is defined as retail pharmacies’ average prices paid to acquire drug products. Average 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 AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average AAC.

l. For purposes of this subrule, “equivalent products” shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, “Approved Prescription Drug Products With Therapeutic Equivalence Evaluations.”

m. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

n. 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 physician payment policy under subrule 79.1(2).

79.1(9) HCBS consumer choices financial management.

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer’s individual budget amount as determined under 441—paragraph 78.34(13) “*b*,” 78.37(16) “*b*,” 78.38(9) “*b*,” 78.41(15) “*b*,” 78.43(15) “*b*,” or 78.46(6) “*b*.”

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to \$10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) Prohibition against reassignment of claims. No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) Prohibition against factoring. Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) Reasonable charges for services, supplies, and equipment. For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the Part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) Copayment by member. A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

- (3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than \$25.
- (4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is \$25.01 to \$50.
- (5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is \$50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

- (1) Total covered service rendered on a given date for dental services and hearing aids.
- (2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving 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 supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency’s financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider’s HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer’s home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer’s home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph “e.”

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph “d.”

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider’s new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph “f.”

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph “f.”

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider’s reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) 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) 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.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer’s needs, or if there is a subsequent change in the consumers at a site or in any consumer’s needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer’s needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site’s average costs.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

“Allowable costs” means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

“Ambulatory payment classification” or *“APC”* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

“Ambulatory payment classification relative weight” or *“APC relative weight”* means the relative value assigned to each APC.

“Ancillary service” means a supplemental service that supports the diagnosis or treatment of the patient’s condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

“APC service” means a service that is priced and paid using the APC system.

“Base year cost report,” for rates effective January 1, 2009, means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“Blended base APC rate” shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

“Case-mix index” shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

“Cost outlier” shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph “g” and are therefore eligible for additional payments above and beyond the base APC payment.

“Current procedural terminology—fourth edition (CPT-4)” is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

“Diagnostic service” means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

“Direct medical education costs” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

“Discount factor” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“Healthcare common procedures coding system” or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that

incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“*Hospital-based clinic*” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“*International classifications of diseases—fourth edition, ninth revision (ICD-9)*” is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person’s injury or illness.

“*Medicaid claim set*” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“*Modifier*” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“*Multiple significant procedure discounting*” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“*Observation services*” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“*Outpatient hospital services*” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“*Outpatient prospective payment system*” or “*OPPS*” means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“*Outpatient visit*” shall mean those hospital-based outpatient services which are billed on a single claim form.

“*Packaged service*” means a service that is secondary to other services but is considered an integral part of another service.

“*Pass-through*” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“*Quality improvement organization*” or “*QIO*” shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rebasing*” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the 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.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as:</p> <ul style="list-style-type: none"> ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPPS APC.</p> <ul style="list-style-type: none"> ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.</p>
F	<p>Certified registered nurse anesthetist services</p> <p>Corneal tissue acquisition</p> <p>Hepatitis B vaccines</p>	<p>If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>

G	Pass-through drugs and biologicals	<p>If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
H	Pass-through device categories	<p>If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.</p>
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	<p>If covered by Iowa Medicaid, the item is:</p> <ul style="list-style-type: none"> • Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. • Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c" when either no APC or APC weight is established. <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
L	Influenza vaccine Pneumococcal pneumonia vaccine	<p>If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.</p>
M	Items and services not billable to the Medicare fiscal intermediary	<p>If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	<p>Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.</p>
P	Partial hospitalization	<p>Not a covered service under Iowa Medicaid.</p>
Q1	STVX-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator "S," "T," "V," or "X." • In all other circumstances, payment is made through a separate APC payment.

Q2	T-packaged codes	<p>Paid under OPSS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” • In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPSS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPSS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPSS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPSS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPSS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPSS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPSS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPSS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPSS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPSS APC or any other Medicaid payment system.</p>
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPSS 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 OPSS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPSS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPSS 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>
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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 and on whether the member is participating in the MediPASS program.

1. For members not participating in the MediPASS program who were referred to the emergency room by appropriate medical personnel and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician, 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 not participating in the MediPASS program 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.

3. For members participating in the MediPASS program who were not referred to the emergency room by their MediPASS primary care physician, no payment will be made for treatment provided in the emergency room.

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 \$2,776,336. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall

request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) Reimbursement for home- and community-based services home and vehicle modification 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 Dental Terminology, Third Edition (CDT-3).

79.1(21) Rehabilitation agencies. Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) Medicare crossover claims for inpatient and outpatient hospital services. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicaid reimbursement" means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph "b" and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph "b." The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) Reimbursement for remedial services. Reimbursement for remedial services 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 case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1) "d." Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is one hour (for up to 7 hours 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 hourly 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 hourly unit shall be used when the member receives services for 1 to 7 hours 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 an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.

2. One hour for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is one hour.

b. Submission of cost reports. The department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report that meets the requirement of paragraph 79.1(24) "b," the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. Reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(25) *Reimbursement for community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled into the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit

Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

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

[ARC 7835B, IAB 6/3/09, effective 7/8/09; ARC 7937B, IAB 7/1/09, effective 7/1/09; ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 8206B, IAB 10/7/09, effective 11/11/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8647B, IAB 4/7/10, effective 3/11/10; ARC 8649B, IAB 4/7/10, effective 3/11/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 8899B, IAB 6/30/10, effective 7/1/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9134B, IAB 10/6/10, effective 10/1/10; ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9176B, IAB 11/3/10, effective 12/8/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; 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]

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) Definitions.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the withholding of all payments due a provider until the resolution of the matter in dispute between the provider and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) Grounds for sanctioning providers. Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

- b.* Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.
- c.* Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.
- d.* Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.
- e.* Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.
- f.* Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.
- g.* Failure to comply with the terms of the provider certification on each medical assistance check endorsement.
- h.* Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.
- i.* Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.
- j.* Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.
- k.* Submission of a false or fraudulent application for provider status under the medical assistance program.
- l.* Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.
- m.* Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.
- n.* Failure to meet standards required by state or federal law for participation, for example, licensure.
- o.* Exclusion from Medicare because of fraudulent or abusive practices.
- p.* Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.
- q.* Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.
- r.* Formal reprimand or censure by an association of the provider's peers for unethical practices.
- s.* Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.
- t.* Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

79.2(3) Sanctions. The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

- a.* A term of probation for participation in the medical assistance program.
- b.* Termination from participation in the medical assistance program.
- c.* Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.
- d.* Suspension or withholding of payments to provider.
- e.* Referral to peer review.
- f.* Prior authorization of services.
- g.* One hundred percent review of the provider's claims prior to payment.
- h.* Referral to the state licensing board for investigation.

i. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

j. Providers with a total Medicaid credit balance of more than \$500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over \$500.

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

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

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

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

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

79.2(5) *Scope of sanction.*

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

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

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

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

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

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

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

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

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

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

79.3(1) Financial (fiscal) records.

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

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

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

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

79.3(2) Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

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

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

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

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

c. *Components.*

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) "d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.

9. Progress or status notes for the services or activities provided.
 10. All forms required by the department as a condition of payment for the services provided.
 11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
 12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
 13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.
- (3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:
1. The specific procedures or treatments performed.
 2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
 3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
 4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)“c” or “d,” 441—paragraph 77.33(6)“d,” 441—paragraph 77.34(5)“d,” 441—paragraph 77.37(15)“d,” 441—paragraph 77.39(13)“e,” 441—paragraph 77.39(14)“d,” or 441—paragraph 77.46(5)“i,” or 441—subparagraph 78.9(10)“a”(1).
 5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
 6. Any supplies dispensed as part of the service.
 7. The first and last name and professional credentials, if any, of the person providing the service.
 8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
 9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.
- (4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.
- d. Basis for service requirements for specific services.* The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise 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.
- (7) Optometrist and optician services:
 1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
 2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
 3. Prior authorization documentation.
- (8) Psychologist services:
 1. Service or office psychotherapy notes or narratives.
 2. Psychological examination report and notes.
- (9) Clinic services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Prescriptions.
 5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
 3. Procedure, laboratory, or test orders and results.
 4. Immunization records.
- (11) Services provided by community mental health centers:
 1. Service referral documentation.
 2. Initial evaluation.
 3. Individual treatment plan.
 4. Service or office notes or narratives.
 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
 6. Written plan for accessing emergency services.
- (12) Screening center services:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Laboratory reports.
 4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Immunization records.
 5. Consent forms.
 6. Prescriptions.
 7. Medication administration records.

- (14) Maternal health center services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
 1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 2. Physician orders.
 3. Consent forms.
 4. Anesthesia records.
 5. Pathology reports.
 6. Laboratory and X-ray reports.
- (17) Hospital services:
 1. Physician orders.
 2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 3. Progress or status notes.
 4. Diagnostic procedures, including laboratory and X-ray reports.
 5. Pathology reports.
 6. Anesthesia records.
 7. Medication administration records.
- (18) State mental hospital services:
 1. Service referral documentation.
 2. Resident assessment and initial evaluation.
 3. Individual comprehensive treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
 1. Physician orders.
 2. Progress or status notes.
 3. Service notes or narratives.
 4. Procedure, laboratory, or test orders and results.
 5. Nurses' notes.
 6. Physical therapy, occupational therapy, and speech therapy notes.
 7. Medication administration records.
 8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:
 1. Physician orders.
 2. Progress or status notes.
 3. Preliminary evaluation.
 4. Comprehensive functional assessment.
 5. Individual program plan.
 6. Form 470-0374, Resident Care Agreement.
 7. Program documentation.
 8. Medication administration records.
 9. Nurses' notes.
 10. Form 470-0042, Case Activity Report.

- (21) Services provided by psychiatric medical institutions for children:
 1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (22) Hospice services:
 1. Physician certifications for hospice care.
 2. Form 470-2618, Election of Medicaid Hospice Benefit.
 3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
 1. Physician orders.
 2. Initial certification, recertifications, and treatment plans.
 3. Narratives from treatment sessions.
 4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
 1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
- (25) Behavioral health intervention:
 1. Order for services.
 2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
- (26) Services provided by area education agencies and local education agencies:
 1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:
 1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
- (28) Services provided by independent laboratories:
 1. Laboratory reports.
 2. Physician order for each laboratory test.
- (29) Ambulance services:
 1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
 1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.

- (31) Medical supplies:
 1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.
 4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
 1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
 1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
 2. Notice of decision for service authorization.
 3. Service notes or narratives.
 4. Social history.
 5. Comprehensive service plan.
 6. Reassessment of member needs.
 7. Incident reports in accordance with 441—subrule 24.4(5).
- (34) Early access service coordinator services:
 1. Individualized family service plan (IFSP).
 2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
 1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.
 6. Invoices or receipts.
 7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
- (36) Physical therapist services:
 1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.
- (37) Chiropractor services:
 1. Service or office notes or narratives.
 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
 1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
 2. Documentation of hearing aid evaluation and selection (Form 470-0828).
 3. Waiver of informed consent.
 4. Prior authorization documentation.
 5. Service or office notes or narratives.
- (39) Behavioral health services:
 1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
- (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.

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]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

“*Authorized representative,*” within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

“*Claim*” means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

“*Clinical record*” means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

“*Confidence level*” means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“*Customary and prevailing fee*” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“*Extrapolation*” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“*Fiscal record*” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“Overpayment” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“Procedure code” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“Random sample” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“Underpayment” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“Universe” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“d” to document the basis for services or activities provided, in the following format:

Iowa Department of Human Services
Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Documentation Checklist

Date of Request: _____
 Reviewer Name & Phone Number: _____
 Provider Name: _____
 Provider Number: _____
 Provider Type: _____

Please sign this form and return it with the information requested.
 Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.

Please send copies. Do not send original records.

If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number
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c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

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

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

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

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

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

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

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

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

(2) Notice is not required for unannounced on-site reviews and audits.

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

d. Audit or review procedures may include, but are not limited to, the following:

- (1) Comparing clinical and fiscal records with each claim.
- (2) Interviewing members who received goods or services and employees of providers.
- (3) Examining third-party payment records.
- (4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. *Use of statistical sampling techniques.* The department’s procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph “a” of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

c. Disagreement with sampling results. When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

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

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

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

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

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

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

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

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

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

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

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) Membership. The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

79.7(3) Expenses, staff support, and technical assistance. Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) Meetings. The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) Procedures.

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.

d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) Duties.

a. Executive committee. Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the

director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

- (1) Recommendations on the reimbursement for medical services rendered by providers of services.
- (2) Identification of unmet medical needs and maintenance needs which affect health.
- (3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.
- (4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.
- (5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. Council. The medical assistance advisory council shall:

- (1) Advise the professional groups and business entities represented and act as liaison between them and the department.
- (2) Report at least annually to the professional groups and business entities represented.
- (3) Perform other functions as may be provided by state or federal law or regulation.
- (4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) Responsibilities.

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

- (1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and
- (2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[ARC 8263B, IAB 11/4/09, effective 12/9/09]

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

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

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

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

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

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

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

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

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

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

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

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

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

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

e. The advice of an appropriate professional consultant.

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

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

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

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

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

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

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers other than managed care organizations and Medicaid fiscal agents shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise Web site.

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).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit by personal delivery, by e-mail, 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.

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.

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 any other; or
- (5) The ability of a third party to control any member of the affiliation.

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 as identified in 42 CFR §455.470.

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]

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 published in the Federal Register, Vol. 75, No. 144, on July 28, 2010. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to July 28, 2010, the department elects the calendar year preceding the payment year as the period used to calculate whether or not an eligible professional is “hospital-based” for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to July 28, 2010, eligible providers may elect to use either:

- (1) The methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010, or
- (2) The methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to July 28, 2010, the “12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to July 28, 2010, 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, defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399.

(3) A children's hospital, defined as a separately certified children's hospital, either freestanding or a hospital-within-hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional's patient volume covered by Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. 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 who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the National Level Repository, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the EHR incentive payment program section of the Iowa Medicaid portal access (IMPA) Web site at <https://secureapp.dhs.state.ia.us/impa/>. The applicant shall use the Web site to:

(1) Attest to the applicant's qualifications to receive the incentive payment, and

(2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, the eligible provider must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) Payment. The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the National Level Repository.

a. The primary communication channel from the department to the provider will be the IMPA Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

(1) Eligibility,

(2) Purchase of certified electronic health record technology, and

(3) Meaningful use of electronic health record technology.

79.16(5) Administrative appeal. Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a. Provider eligibility determination.
- b. Incentive payments.
- c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

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 - [Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]
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◊ Two or more ARCs

- ¹ Effective date of 79.1(2) and 79.1(5) "t" delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.
- ² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.
- ³ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.
- ⁴ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- ⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁶ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁷ July 1, 2009, effective date of amendments to 79.1(1) "d," 79.1(2), and 79.1(24) "a"(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ⁸ 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).

CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

DIVISION I—HCBS ILL AND HANDICAPPED WAIVER SERVICES

441—83.1(249A) Definitions.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Blind individual” means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of ill and handicapped waiver services exclusive of medical vendor payments before Medicaid will participate.

“Deeming” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“Disabled person” means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

“Financial participation” means client participation and medical payments from a third party including veterans’ aid and attendance.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Intermittent homemaker service” means homemaker service provided from one to three hours a day for not more than four days per week.

“Intermittent respite service” means respite service provided from one to three times a week.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Substantial gainful activity*” means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.2(249A) Eligibility. To be eligible for ill and handicapped waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) Eligibility criteria.

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. The person must be ineligible for Supplemental Security Income (SSI) if the person is 21 years of age or older, except that persons who are receiving ill and handicapped waiver services upon reaching the age of 21 may continue to be eligible regardless of SSI eligibility until they reach the age of 25.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent’s(s’) income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse’s income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person’s income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) Ill and handicapped waiver services will not be provided when the person is an inpatient in a medical institution.

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical

emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician or a physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at paragraphs 441—75.5(2) “*b*” and 441—75.5(4) “*c*” shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) Need for services.

a. The consumer shall have a service plan approved by the department which is developed by the service worker identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The service worker shall establish the interdisciplinary team for the consumer and, with the team, identify the consumer's need for service based on the consumer's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually. The service worker shall have a face-to-face visit with the member at least annually.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The service worker shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the consumer's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the ill and handicapped waiver services shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$2,684	\$922	\$3,267

(1) For members eligible for SSI who remain eligible for ill and handicapped waiver services until the age of 25 because they are receiving ill and handicapped waiver services upon reaching the age of 21, these amounts shall be increased by the cost of services for which the member would be eligible under 441—subrule 78.9(10) if still under 21 years of age.

(2) If more than \$505 is paid for home and vehicle modification services, the service worker shall encumber up to \$505 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13]

441—83.3(249A) Application.

83.3(1) *Application for HCBS ill and handicapped waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS ill and handicapped waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS ill and handicapped waiver. The number of consumers to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of consumers specified in the approved waiver, the applicant’s name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)“a”(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) Approval of application.

a. Applications for the HCBS ill and handicapped waiver program shall be processed in 30 days unless one or more of the following conditions exist:

- (1) An application has been filed and is pending for federal supplemental security income benefits.
- (2) The application is pending because the department has not received information which is beyond the control of the client or the department.
- (3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(5) The application is pending because the assessment, Form 470-4392, or the service plan has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, Form 470-4392, or service plan, the application shall be denied.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the client case plan are completed.

c. An applicant must be given the choice between HCBS ill and handicapped waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A consumer may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the consumer is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) Effective date of eligibility.

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations and the case plan are completed, but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the ill and handicapped waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs "a" and "c" of this subrule do not apply is the date on which the income eligibility and level of care determinations and the case plan are completed.

c. Eligibility for persons covered under subrule 83.2(1)"c"(3) shall exist on the date the income and resource eligibility and level of care determinations and case plan are completed, but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the consumer has been in a medical institution for 30 consecutive days for other than respite care. Consumers who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from ill and handicapped waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical

institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of ill and handicapped waiver services or other Medicaid services, as applicable.

83.4(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker for ill and handicapped waiver services, Medicaid shall make no payments to ill and handicapped waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the ill and handicapped waiver shall be completed at least once every 12 months or when there is significant change in the person's situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current case plan meeting the requirements listed in rule 441—83.7(249A).

441—83.6(249A) Allowable services. Services allowable under the ill and handicapped waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

441—83.7(249A) Service plan. A service plan shall be prepared for ill and handicapped waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.7(1) The service plan shall include the frequency of the ill and handicapped waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the aggregate monthly costs established in 83.2(2) "b," or are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 130.5(2) “a,” “b,” “c,” “g,” or “h” apply.
- b. The costs of the ill and handicapped waiver service for the person exceed the aggregate monthly costs established in 83.2(2) “b.”
- c. The client receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 30 days in any one stay for purposes other than respite care.
- d. The client receives ill and handicapped waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the service worker.
- e. Service providers are not available.

83.8(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”
 [ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.
 These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to 83.20 Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*Interdisciplinary team*” means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client’s need for services.

“*Medical institution*” means a nursing facility which has been approved as a Medicaid vendor.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) Eligibility criteria. All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.
 b. A resident of the state of Iowa.
 c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)“b” and 75.5(4)“c” shall be applied.

d. Certified as being in need of the intermediate or skilled level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) Need for services, service plan, and cost.

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to 441—subrule 77.33(21). Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. *Interdisciplinary team.* The case manager shall establish an interdisciplinary team for the consumer.

(1) *Composition.* The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer’s legal representative, family, service providers, and others directly involved in the consumer’s care.

(2) *Role.* The team shall identify:

1. The consumer’s need for services based on the consumer’s needs and desires.

2. Available and appropriate services to meet the consumer’s needs.

3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.

4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer’s needs change.

c. *Service plan.* An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs are limited as follows:

Skilled level of care

\$2,684

Nursing level of care

\$1,300

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

d. Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:

- (1) Observable or measurable individual goals.
- (2) Interventions and supports needed to meet those goals.
- (3) Incremental action steps, as appropriate.
- (4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.
 2. The funding source for the service.
 3. The amount of service that the consumer is to receive.
- (9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.
2. The emergency backup support and crisis response system identified by the interdisciplinary team.
3. Emergency, backup staff designated by providers for applicable services.

83.22(3) Providers—standards. Rescinded IAB 10/11/06, effective 10/1/06.
[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13]

441—83.23(249A) Application.

83.23(1) Application for HCBS elderly waiver. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) Application for services. Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) Approval of application.

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) Effective date of eligibility.

a. The effective date of eligibility cannot precede the date the case manager signs the case plan.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.24(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

83.27(1) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a.* The independent support broker selected by the consumer; and
- b.* The financial management service selected by the consumer.

83.27(2) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) Denial. An application for services shall be denied when it is determined by the department that:

- a.* The client is not eligible for or in need of services.

b. Except for respite care, the elderly waiver services are not needed on a regular basis.
 c. Service needs exceed the aggregate monthly costs established in 83.22(2) “b,” or are not met by services provided.

d. Needed services are not available or received from qualifying providers.

e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.

b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2) “b.”

c. The client receives care in a hospital or nursing facility for 30 days in any one stay for purposes other than respite care.

d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the case manager and the interdisciplinary team.

e. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person’s primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to 83.40 Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

“*AIDS*” means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of “Morbidity and Mortality Weekly Report.”

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient’s income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Deeming*” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“*Financial participation*” means client participation and medical payments from a third party including veterans’ aid and attendance.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*HIV*” means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

“*Medical institution*” means a nursing facility or hospital which has been approved as a Medicaid vendor.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Be diagnosed by a physician as having AIDS or HIV infection.
- b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) Need for services.

a. The department service worker shall perform an assessment of the person’s need for waiver services and determine the availability and appropriateness of services. This assessment shall be based, in part, on information in the completed Service Worker Comprehensive Assessment, Form 470-5044. Form 470-5044 shall be completed annually.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of \$1,786.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13]

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations and the service plan are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations and the service plan are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations and the service plan are completed, but shall not be earlier than the first of the month following the date of application.

83.43(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) Limitation on payment. If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.47(3) Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.42(2) "b" or cannot be met by the services provided under the waiver.
- d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph "a," "b," "c," "d," "g," or "h" apply.
- b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2) "b."
- c. The client receives care in a hospital or nursing facility for 30 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “*a*” and “*b*.”

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

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

441—83.51 to 83.59 Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“*Adult*” means a person with an intellectual disability aged 18 or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

“*Assessment*” means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Case management services*” means those services established pursuant to Iowa Code chapter 225C.

“*Child*” means a person with an intellectual disability aged 17 or under.

“*Client participation*” means the posteligibility amount of the consumer's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

“*Counseling*” means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

“*Deemed status*” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“*Department*” means the Iowa department of human services.

“*Direct service*” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“*Fiscal accountability*” means the development and maintenance of budgets and independent fiscal review.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*Health*” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“*Immediate jeopardy*” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“*Intellectual disability*” means a diagnosis of mental retardation which shall be made only when the onset of the person’s condition was before the age of 18 years and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. A diagnosis of mental retardation shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, published by the American Psychiatric Association.

“*Intermediate care facility for persons with an intellectual disability (ICF/ID)*” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“*Intermittent supported community living service*” means supported community living service provided not more than 52 hours per month.

“*Maintenance needs*” means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

“*Managed care*” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“*Medical assessment*” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“*Medical institution*” means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“*Medical intervention*” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“*Medical monitoring*” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“*Natural supports*” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“*Organization*” means the entity being certified.

“*Organizational outcome*” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“*Outcome*” means an action or event that follows as a result or consequence of the provision of a service or support.

“*Procedures*” means the steps to be taken to implement a policy.

“*Process*” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified intellectual disability professional” means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.
10. A human services professional who must have at least a bachelor’s degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

“Related condition” means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.
2. It is manifested before the age of 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - Self-care.
 - Understanding and use of language.
 - Learning.
 - Mobility.
 - Self-direction.
 - Capacity for independent living.

“Service plan” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“Staff” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“Third-party payments” means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs

incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

“Usual caregiver” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Have a diagnosis of mental retardation or, for residential-based supported community living services only, be a person with a related condition as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound mental retardation	Recertification for persons with a diagnosis of mild or unspecified mental retardation
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of mental retardation or, for residential-based supported community living services, a diagnosis of a related condition as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of mental retardation or, for residential-based supported community living services, a diagnosis of a related condition as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of mental retardation or, for residential-based supported community living services, a diagnosis of a related condition as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 through 21 years	<ul style="list-style-type: none"> • Psychological documentation substantiating diagnosis of mental retardation within three years before the application date, or • Diagnosis of mental retardation made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation 	Psychological documentation substantiating a diagnosis of mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation every five years and whenever a significant change occurs
22 years and above	Diagnosis made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation if the last testing date was (1) more than five years ago for an applicant with a diagnosis of mild or unspecified mental retardation, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound mental retardation	Psychological documentation substantiating a diagnosis of mental retardation made since the member reached 18 years of age	Psychological documentation substantiating a diagnosis of mental retardation every six years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

(1) to (3) Rescinded IAB 3/7/01, effective 5/1/01.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For supported employment services:

(1) Be at least age 16.

(2) Rescinded IAB 7/1/98, effective 7/1/98.

(3) Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.

(4) Not reside in a medical institution.

h. Choose HCBS intellectual disability waiver services rather than ICF/ID services.

i. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

j. Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

k. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:

1. Social history;

2. Case history that includes previous placements and service programs;

3. Medical history that includes major illnesses and current medications;

4. Current psychological evaluations and consultations;

5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;

6. Any current court orders in effect regarding the child;

7. Any legal history;

8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;

9. Whether the proposed placement would be safe for the child and for other children living in that setting; and

10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;

2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)“a”; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

l. For day habilitation, be 16 years of age or older.

m. For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) Need for services.

a. Applicants currently receiving Medicaid case management or services of a department-qualified intellectual disability professional (QIDP) shall have the applicable coordinating staff and other

interdisciplinary team members complete Form 470-4694, Case Management Comprehensive Assessment, and identify the applicant's needs and desires as well as the availability and appropriateness of the services.

b. Applicants not receiving services as set forth in paragraph 83.61(2) "a" shall have a department service worker or case manager:

(1) Complete Form 470-4694, Case Management Comprehensive Assessment, for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The service worker, department QMRP, or Medicaid case manager shall complete Form 470-4694, Case Management Comprehensive Assessment, for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary for completion of Form 470-4694 or other circumstances beyond the worker's control.

g. At initial enrollment, the service worker, department QIDP, case manager or Medicaid case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing assessments:

(1) The assessment shall be based, in part, on information on the completed Case Management Comprehensive Assessment, Form 470-4694.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) HCBS intellectual disability waiver program limit. The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person’s name will be put on a waiting list shall be sent to the person by the department.

83.61(4) Securing a payment slot. The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant’s priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4) “b”(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4) “b”(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant’s need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker’s control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating the consumer’s choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Rescinded IAB 5/6/09, effective 7/1/09.

83.62(4) Effective date of eligibility.

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

83.67(1) Development. The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) Retention. The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) Interdisciplinary team meeting. The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.67(5) Documentation. The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) Approval of plan. The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

- a. Services must be authorized and entered into ISIS before the plan implementation date.
- b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.
- c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.68(249A) Adverse service actions.

83.68(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The applicant is not eligible for the services.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.

g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

83.68(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b. Needed services are not available or received from qualifying providers.
- c. No HCBS intellectual disability waiver service is identified in the member’s annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.
- g. The consumer receives services from other Medicaid waiver programs.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.70(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.71(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

441—83.72(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to 83.80 Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

“*Adaptive*” means age appropriate skills related to taking care of one’s self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“*Adult*” means a person with a brain injury aged 18 years or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

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

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Brain injury*” means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person’s physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

- Malignant neoplasms of brain, cerebrum.
- Malignant neoplasms of brain, frontal lobe.
- Malignant neoplasms of brain, temporal lobe.
- Malignant neoplasms of brain, parietal lobe.
- Malignant neoplasms of brain, occipital lobe.
- Malignant neoplasms of brain, ventricles.
- Malignant neoplasms of brain, cerebellum.
- Malignant neoplasms of brain, brain stem.
- Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.

- Malignant neoplasms of brain, cerebral meninges.
- Malignant neoplasms of brain, cranial nerves.
- Secondary malignant neoplasm of brain.
- Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.
- Benign neoplasm of brain and other parts of the nervous system, brain.
- Benign neoplasm of brain and other parts of the nervous system, cranial nerves.
- Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.
- Encephalitis, myelitis and encephalomyelitis.
- Intracranial and intraspinal abscess.
- Anoxic brain damage.
- Subarachnoid hemorrhage.
- Intracerebral hemorrhage.
- Other and unspecified intracranial hemorrhage.
- Occlusion and stenosis of precerebral arteries.
- Occlusion of cerebral arteries.
- Transient cerebral ischemia.
- Acute, but ill-defined, cerebrovascular disease.
- Other and ill-defined cerebrovascular diseases.
- Fracture of vault of skull.
- Fracture of base of skull.
- Other and unqualified skull fractures.
- Multiple fractures involving skull or face with other bones.
- Concussion.
- Cerebral laceration and contusion.
- Subarachnoid, subdural, and extradural hemorrhage following injury.
- Other and unspecified intracranial hemorrhage following injury.
- Intracranial injury of other and unspecified nature.
- Poisoning by drugs, medicinal and biological substances.
- Toxic effects of substances.
- Effects of external causes.
- Drowning and nonfatal submersion.
- Asphyxiation and strangulation.
- Child maltreatment syndrome.
- Adult maltreatment syndrome.

“*Case management services*” means those services established pursuant to Iowa Code chapter 225C.

“*Child*” means a person with a brain injury aged 17 years or under.

“*Client participation*” means the amount of the consumer’s income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“*Deemed status*” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“*Department*” means the Iowa department of human services.

“*Direct service*” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“*Fiscal accountability*” means the development and maintenance of budgets and independent fiscal review.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*Health*” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“*Immediate jeopardy*” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“*Intermittent supported community living service*” means supported community living service provided from one to three hours a day for not more than four days a week.

“*Medical assessment*” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“*Medical institution*” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“*Medical intervention*” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“*Medical monitoring*” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“*Natural supports*” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“*Organization*” means the entity being certified.

“*Organizational outcome*” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“*Outcome*” means an action or event that follows as a result or consequence of the provision of a service or support.

“*Procedures*” means the steps to be taken to implement a policy.

“*Process*” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“*Qualified brain injury professional*” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

“*Service coordination*” means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a diagnosis of brain injury.
- b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.
- c. Be aged 1 month to 64 years.
- d. Be a U.S. citizen and Iowa resident.
- e. Rescinded IAB 7/11/01, effective 7/1/01.
- f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care.
- g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.
- h. At a minimum, receive a waiver service each quarter in addition to case management.
- i. Choose HCBS.
- j. To be eligible for interim medical monitoring and treatment services the consumer must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
 - (3) Residing in the consumer’s family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician.
- k. Receive services in a community, not an institutional, setting.
- l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.
- m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

83.82(2) Need for services.

- a. The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant’s need for service based on the applicant’s needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

d. The total cost of brain injury waiver services shall not exceed \$2,868 per month. If more than \$505 is paid for home and vehicle modification services, the service worker shall encumber up to \$505 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the appropriate case manager for the consumer's county of residence to initiate development of the consumer's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of a consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) Use of nonwaiver services. Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) Annual assessment. The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed Form 470-4694, Case Management Comprehensive Assessment, and supporting documentation as needed.

83.87(4) Service file. The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to d. Rescinded IAB 8/7/02, effective 10/1/02.
 [ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.88(249A) Adverse service actions.

83.88(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the service unit or reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The brain injury waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.88(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph "d," "g," or "h," apply.

- b. Needed services are not available or received from qualifying providers.
- c. The brain injury waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12]

441—83.90(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.91(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to 83.100 Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

“Adaptive” means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“Adult” means a person with a physical disability aged 18 years to 64 years.

“Appropriate” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

“Assessment” means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Behavior” means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Client participation” means the amount of the consumer's income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“Department” means the Iowa department of human services.

“Guardian” means a guardian appointed in probate court for an adult.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Physical disability” means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

“*Service plan*” means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It may involve more than one provider.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Waiver year*” means a 12-month period commencing on April 1 of each year.
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a physical disability.
- b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.
- c. Be ineligible for the HCBS intellectual disability waiver.
- d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.
- e. Be eligible for Medicaid under 441—Chapter 75.
- f. Be aged 18 years to 64 years.
- g. Rescinded IAB 2/7/01, effective 2/1/01.
- h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(3) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

- i. Choose HCBS.
- j. Use a minimum of one unit of service per calendar quarter under this program.
- k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) Need for services.

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The service worker shall identify the need for service based on the needs of the applicant, as documented in Form 470-5044, Service Worker Comprehensive Assessment, as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services shall not exceed \$672 per month. If more than \$505 is paid for home and vehicle modification services, the service worker shall encumber up to \$505 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.

83.102(3) Slots. The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) County payment slots for persons requiring the ICF/MR level of care. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) Securing a slot.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) Securing a county payment slot. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) HCBS physical disability waiver waiting list. When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13]

441—83.103(249A) Application.

83.103(1) Application for financial eligibility. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) Approval of application for eligibility.

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall have the applicant's primary care provider complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's primary care provider shall complete Form 470-4392, Level of Care Certification for HCBS Waiver Program, and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign Form 470-5044, Service Worker Comprehensive Assessment, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the service worker in the development of the service plan, which must be approved by the department service worker prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.102(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.102(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) *Computation of client participation.* Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) *Redetermination.* A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) *Allowable services.* The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) *Individual service plan.* An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer and the DHS service worker prior to services beginning and payment being made to the provider. The plan shall be reviewed by the consumer and the service worker annually, and the current version approved by the service worker.

83.107(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. The name of all providers responsible for providing all services.
- c. All service funding sources.
- d. The amount of the service to be received by the consumer.
- e. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.107(2) *Annual assessment.* The IME medical services unit shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process at rule 441—83.109(249A), based on the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, and supporting documentation as needed.

83.107(3) *Case file.* Rescinded IAB 8/7/02, effective 10/1/02.
[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.108(249A) *Adverse service actions.*

83.108(1) *Denial.* An application for services shall be denied when it is determined by the department that:

- a. All of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.

e. The physical disability waiver service is not identified in the consumer's service plan.
f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative requests termination from the services.

83.108(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

83.108(3) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.

b. Needed services are not available or received from qualifying providers.

c. The physical disability waiver service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

83.109(1) Appeal to county. Rescinded IAB 2/7/01, effective 2/1/01.

83.109(2) Reconsideration request to IME medical services unit. Rescinded IAB 9/5/12, effective 11/1/12.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to 83.120 Reserved.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

“*Assessment*” means the review of the consumer's current functioning in regard to the consumer's situation, needs, abilities, desires, and goals.

“*Case manager*” means the person designated to provide Medicaid targeted case management services for the consumer.

“*CMS*” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“*Consumer*” means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children's mental health waiver services.

“*Deeming*” means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

“*Department*” means the Iowa department of human services.

“*Guardian*” means a parent of a consumer or a legal guardian appointed by the court.

“*HCBS*” means home- and community-based services provided under a Medicaid waiver.

“*IME*” means the Iowa Medicaid enterprise.

“*IME medical services unit*” means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children’s mental health waiver services.

“*Interdisciplinary team*” means the consumer, the consumer’s family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer’s needs, as designated by the consumer and the consumer’s family, who meet to develop a service plan based on the individualized needs of the consumer.

“*ISIS*” means the department’s individualized services information system.

“*Local office*” means a department of human services office as described in 441—subrule 1.4(2).

“*Medical institution*” means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

“*Mental health professional*” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and
2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and
3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“*Serious emotional disturbance*” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer’s role or functioning in family, school, or community activities. “Serious emotional disturbance” shall not include developmental disorders, substance-related disorders, or conditions or problems classified in DSM-IV-TR as “other conditions that may be a focus of clinical attention” (V codes), unless these conditions co-occur with another diagnosable serious emotional disturbance.

“*Service plan*” means a written, consumer-centered, outcome-based plan of services developed by the consumer’s interdisciplinary team that addresses all relevant services and supports being provided. The service plan may involve more than one provider.

“*Skill development*” means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

“*Targeted case management*” means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children’s mental health waiver.

“*Waiver year*” for the children’s mental health waiver means a 12-month period commencing on July 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.122(249A) Eligibility. To be eligible for children’s mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) Age. The consumer must be under 18 years of age.

83.122(2) Diagnosis. The consumer must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children’s mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) *Level of care.* The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit shall certify the applicant's level of care annually based on Form 470-4694, Case Management Comprehensive Assessment.

83.122(4) *Financial eligibility.* The consumer must be eligible for Medicaid as follows:

- a. Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group;
- or
- b. Be eligible under the special income level (300 percent) coverage group; or
- c. Become eligible through application of the institutional deeming rules; or
- d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) *Choice of program.* The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on Form 470-4694, Case Management Comprehensive Assessment.

83.122(6) *Need for service.* The consumer must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

a. The consumer must be a recipient of targeted case management services or be identified to receive targeted case management services immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the member's needs may not exceed \$1,910 per month.

c. At a minimum, each consumer must receive one billable unit of a children's mental health waiver service per calendar quarter.

d. A consumer may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A consumer may be enrolled in only one HCBS waiver program at a time.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13]

441—83.123(249A) *Application.* The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children's mental health waiver services.

83.123(1) *Program limit.* The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer's application shall be rejected and the consumer's name shall be placed on a waiting list.

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member;

(2) Form 470-4694, Case Management Comprehensive Assessment, with HCBS waiver choice indicated by signature of a Medicaid member's parent or legal guardian; or

(3) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

c. If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1) "a."

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

83.123(2) Approval of waiver eligibility.

a. *Time limit.* Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment or the service plan has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a service plan, the application shall be denied.

b. *Notice of decisions.* The department shall mail or give decisions to the applicant on the dates when eligibility and level-of-care determinations and the consumer's service plan are completed.

83.123(3) Effective date of eligibility. The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met;

b. Eligibility and level-of-care determinations have been made; and

c. The service plan has been completed.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.124(249A) Financial participation. A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

441—83.125(249A) Redetermination. The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

83.125(1) Eligibility review. Every 12 months, the local office shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify:

a. Continuing eligibility factors as specified in rule 441—83.122(249A).

b. The existence of a current service plan meeting the requirements listed in rule 441—83.125(249A).

83.125(2) Continuation of eligibility. A consumer's waiver eligibility shall continue until one of the following conditions occurs.

- a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).
- b. The consumer is an inpatient of a medical institution for 30 or more consecutive days.

(1) After the consumer has spent 30 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 30 consecutive days but no more than 60 days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

83.125(3) Payment slot. When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

- 1. Environmental modifications, adaptive devices and therapeutic resources;
- 2. Family and community support services;
- 3. In-home family therapy; and
- 4. Respite care.

441—83.127(249A) Service plan. The consumer's case manager shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan shall be developed through an interdisciplinary team process.

83.127(2) The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

83.127(3) The service plan shall be based on information in Form 470-4694, Case Management Comprehensive Assessment.

83.127(4) The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan shall identify and justify any restriction of the consumer's rights.

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

441—83.128(249A) Adverse service actions.

83.128(1) Denial. An application for children's mental health waiver services shall be denied when the department determines that:

- a. The consumer is not eligible for or in need of waiver services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6) "c" or are not met by the services provided.

83.128(2) Termination. A consumer's participation in the children's mental health waiver program may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) "a," "b," "c," "g," or "h" apply.
- b. The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6) "c."
- c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 30 days in any one stay.

d. The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager.

e. Service providers are not available.

83.128(3) Reduction. Reduction of services shall apply as specified in 441—paragraphs 130.5(3) “a” and “b.”

441—83.129(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12]

These rules are intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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CHAPTER 110
CHILD DEVELOPMENT HOMES

[Prior to 7/1/83, Social Services[770] Ch 110]

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

PREAMBLE

This chapter establishes registration procedures for child development homes. Included are application and renewal procedures, standards for providers, and procedures for compliance checks and complaint investigation.

441—110.1(237A) Definitions.

“Adult” means a person aged 18 or older.

“Assistant” means a responsible person aged 14 or older. The assistant may never be left alone with children. Ultimate responsibility for supervision is with the child care provider.

“Child” means either of the following:

1. A person 12 years of age or younger.
2. A person 13 years of age or older but younger than 19 years of age who has a developmental disability, as defined under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law No. 106-402, codified in 42 U.S.C. 15002(8).

“Child care” means the care, supervision, or guidance of a child by a person other than the child’s parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis. Child care shall not mean special activity programs that meet on a regular basis such as music or dance classes, organized athletics or sports programs, scouting programs, or hobby or craft classes or clubs.

“Child care facility” or *“facility”* means a child care center, a preschool, or a registered child development home.

“Child care home” means a person or program providing child care to five or fewer children at any one time that is not registered to provide child care under this chapter, as authorized under Iowa Code section 237A.3.

“Child development home” means a person or program registered under this chapter that may provide child care to six or more children at any one time.

“Department” means the department of human services.

“Involvement with child care” means licensed or registered as a child care facility, employed in a child care facility, residing in a child care facility, receiving public funding for providing child care, providing child care as a child care home provider, or residing in a child care home.

“Parent” means parent or legal guardian.

“Part-time hours” means the hours that child development homes in categories B and C are allowed to exceed their maximum preschool or school-age capacity. A provider may use a total of up to 180 hours per month as part-time hours. No more than two children using part-time hours may be in the child development home at any one time.

“Person subject to an evaluation” means a person who has committed a transgression and who is described by any of the following:

1. The person is being considered for registration or is registered.
2. The person is being considered by a child care facility for employment involving direct responsibility for a child or with access to a child when the child is alone, or the person is employed with such responsibilities.
3. The person will reside or resides in a child care facility.
4. The person has applied for or receives public funding for providing child care.
5. The person will reside or resides in a child care home that is not registered but that receives public funding for providing child care.

“Provider” means the person or program that applies for registration to provide child care and is approved as a child development home.

“*Registration*” means the process by which child care providers certify that they comply with rules adopted by the department.

“*Registration certificate*” means the written document issued by the department to publicly state that the provider has certified in writing compliance with the minimum requirements for registration of a child development home.

“*School*” means kindergarten or a higher grade level.

“*Transgression*” means the existence of any of the following in a person’s record:

1. Conviction of a crime.
2. A record of having committed founded child or dependent adult abuse.
3. Listing in the sex offender registry established under Iowa Code chapter 692A.
4. A record of having committed a public or civil offense.
5. Department revocation or denial of a child care facility registration or license due to the person’s continued or repeated failure to operate the child care facility in compliance with licensing and registration laws and rules.

441—110.2(237A) Application for registration. A provider shall apply for registration on Form 470-3384, Application for Child Development Home Registration, provided by the department’s local office or, if available, on the department’s Web site. The provider shall also use Form 470-3384 to inform the department of any changes in circumstances that would affect the registration.

441—110.3(237A) Renewal. Renewal of registration shall be completed every 24 months. To request renewal, a provider shall submit Form 470-3384, Application for Child Development Home Registration, and copies of certificates of training, to be retained in the registration file. The renewal process shall include completion of child abuse, sex offender, and criminal record checks.

441—110.4(237A) Number of children. The number of children shall conform to the following standards:

110.4(1) Limit. Except as provided in subrule 110.4(3), no greater number of children shall be received for care at any one time than the number authorized on the registration certificate.

110.4(2) Children counted. In determining the number of children cared for at any one time in a child development home, each child present in the child development home shall be considered to be receiving care unless the child is described by one of the following exceptions:

a. The child’s parent, guardian, or custodian established or operates the child development home and either the child is attending school or the child receives child care full-time on a regular basis from another person.

b. The child has been present in the child development home for more than 72 consecutive hours and meets the requirements of the exception in paragraph “*a*” as though the person who established or operates the child development home is the child’s parent, guardian, or custodian.

110.4(3) Exception for emergency school closing. On days when schools are closed due to emergencies such as inclement weather or physical plant failure, a child development home may have additional children present in accordance with the authorization for the registration category of the home and subject to all of the following conditions:

a. The child development home has prior written approval from the parent or guardian of each child present in the home concerning the presence of additional children in the home.

b. The child development home has a department-approved assistant, aged 14 or older, on duty to assist the care provider, as required for the registration category of the home.

c. One or more of the following conditions are applicable to each of the additional children present in the child development home:

- (1) The home provides care to the child on a regular basis for periods of less than two hours.
- (2) If the child were not present in the child development home, the child would be unattended.
- (3) The home regularly provides care to a sibling of the child.

d. The provider shall maintain a written record including the date of the emergency school closing, the reason for the closing, and the number of children in care on that date.

441—110.5(237A) Standards. The provider shall certify that the child development home meets the following standards and also the standards in either rule 441—110.8(237A), 441—110.9(237A), or 441—110.10(237A), specific to the category of home for which the provider requests registration.

110.5(1) Health and safety. Conditions in the home shall be safe, sanitary, and free of hazards.

a. The home shall have a non-pay, working telephone with emergency numbers posted for police, fire, ambulance, and the poison information center. If the working telephone is a mobile telephone, these numbers must be programmed and saved into the telephone. The number for each child's parent, for a responsible person who can be reached when the parent cannot, and for the child's physician shall be readily accessible by the telephone. If the working telephone is a mobile telephone, these numbers must also be programmed and saved into the telephone.

b. All medicines and poisonous, toxic, or otherwise unsafe materials shall be secured from access by a child.

c. A first-aid kit shall be available and easily accessible whenever children are in the child development home, in the outdoor play area, in vehicles used to transport children, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

d. Medications shall be given only with the parent's or doctor's written authorization. Each prescribed medication shall be accompanied by a physician's or pharmacist's direction. Both nonprescription and prescription medications shall be in the original container with directions intact and labeled with the child's name. All medications shall be stored properly and, when refrigeration is required, shall be stored in a separate, covered container so as to prevent contamination of food or other medications. All medications shall be stored so they are inaccessible to children.

e. Electrical wiring shall be maintained with all accessible electrical outlets safely capped and electrical cords properly used. Improper use includes running cords under rugs, over hooks, through door openings, or other use that has been known to be hazardous.

f. Combustible materials shall be kept away from furnaces, stoves, water heaters, and gas dryers.

g. Approved safety gates at stairways and doors shall be provided and used as needed.

h. A safe outdoor play area shall be maintained in good condition throughout the year. The play area shall be fenced off when located on a busy thoroughfare or near a hazard which may be injurious to a child, and shall have both sunshine and shade areas. The play area shall be kept free from litter, rubbish, and flammable materials and shall be free from contamination by drainage or ponding of sewage, household waste, or storm water.

i. Annual laboratory analysis of a private water supply shall be conducted to show satisfactory bacteriological quality. When children under the age of two are to be cared for, the analysis shall include a nitrate analysis. When private water supplies are determined unsuitable for drinking, commercially bottled water or water treated through a process approved by the health department or designee shall be provided.

j. Emergency plans in case of man-made or natural disaster shall be written and posted by the primary and secondary exits. The plans shall clearly map building evacuation routes and tornado and flood shelter areas.

k. Fire and tornado drills shall be practiced monthly and the provider shall keep documentation evidencing compliance with monthly practice on file.

l. A safety barrier shall surround any heating stove or heating element, in order to prevent burns.

m. The home shall have at least one 2A 10BC rated fire extinguisher located in a visible and readily accessible place on each child-occupied floor.

n. The home shall have at least one single-station, battery-operated, UL-approved smoke detector in each child-occupied room and at the top of every stairway. Each smoke detector shall be installed according to manufacturer's recommendations. The provider shall test each smoke detector monthly and keep a record of testing for inspection purposes.

o. Smoking and the use of tobacco products shall be prohibited at all times in the home and in every vehicle in which children receiving care in the home are transported. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during the home's hours of operation. Nonsmoking signs shall be posted at every entrance of the child care home and in every vehicle used to transport children. All signs shall include:

- (1) The telephone number for reporting complaints, and
- (2) The Internet address of the department of public health (www.iowasmokefreeair.gov).

p. Children under the age of one year shall be placed on their backs when sleeping unless otherwise authorized in writing by a physician.

q. Providers shall inform parents of the presence of any pet in the home.

(1) Each dog or cat in the household shall undergo an annual health examination by a licensed veterinarian and be issued a veterinary health certificate. This certificate shall verify that the animal's routine immunizations, particularly rabies, are current and that the animal is free of endoparasites (e.g., roundworms, hookworms, whipworms) and ectoparasites (e.g., fleas, mites, ticks, lice).

(2) Each pet bird in the household shall be purchased from a dealer licensed by the Iowa department of agriculture and land stewardship and shall be examined by a veterinarian to verify that it is free of infectious diseases. Children shall not handle pet birds.

(3) Aquariums shall be well maintained and installed in a manner that prevents children from accessing the water or pulling over a tank.

(4) All animal waste shall be immediately removed from the children's areas and properly disposed of. Children shall not perform any feeding or care of pets or cleanup of pet waste.

(5) No animals shall be allowed in the food preparation, food storage, or serving areas during food preparation and serving times.

r. When there is a swimming or wading pool on the premises:

(1) A wading pool shall be drained daily and shall be inaccessible to children when it is not in use.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the standards of the American Society for Testing and Materials.

(3) An uncovered aboveground swimming pool shall be enclosed with an approved fence that is four feet above the side walls.

(4) An uncovered in-ground swimming pool shall be enclosed with a fence that is at least four feet high and flush with the ground.

s. If children are allowed to use an aboveground or in-ground swimming pool:

(1) Written permission from parents shall be available for review.

(2) Equipment needed to rescue a child or adult shall be readily accessible.

(3) The child care provider shall accompany the children and provide constant supervision while the children use the pool.

(4) The child care provider shall complete training in cardiopulmonary resuscitation for infants, toddlers, and children, according to the criteria of the American Red Cross or the American Heart Association.

t. Homes served by private sewer systems shall be compliant with environmental protection commission rules on wastewater treatment and disposal systems at 567—Chapter 69. Compliance shall be verified by the local board of health within 12 months of renewal or new registration.

u. The provider shall have written policies regarding the care of mildly ill children and exclusion of children due to illness and shall inform parents of these policies.

v. The provider shall have written policy and procedures for responding to health-related emergencies.

w. The provider shall document all injuries that require first aid or medical care using an injury report form. The form shall be completed on the date of occurrence, shared with the parent, and maintained in the child's file.

x. A provider operating in a facility built before 1960 shall assess and control lead hazards before being issued an initial child development home registration or a renewal of the registration. To comply with this requirement, the provider shall:

(1) Conduct a visual assessment of the facility for lead hazards that exist in the form of peeling or chipping paint;

(2) Apply interim controls on any chipping or peeling paint found, using lead-safe work methods in accordance with and as defined by department of public health rules at 641—Chapters 69 and 70, unless a certified inspector as defined in 641—Chapter 70 determines that the paint is not lead-based paint; and

(3) Submit Form 470-4755, Lead Assessment and Control, as verification of the visual assessment and completion of interim controls, if necessary.

EXCEPTION: Providers that have a valid registration on November 1, 2009, shall assess and control lead hazards by June 30, 2010.

110.5(2) Provider files. A provider file shall be maintained and shall contain the following:

a. A physician's signed statement that the provider and members of the provider's household are free of diseases or disabilities that would prevent good child care. This statement shall:

(1) Be obtained at the time of the first registration and at least every two years thereafter on all members of the provider's household that may be present when children are in the home.

(2) Include immunization or immune status for measles, mumps, rubella, diphtheria, tetanus, and polio. Providers may consult with their physician regarding recommendations for varicella, influenza, pneumonia, hepatitis A, and hepatitis B immunizations.

b. Certificates or other documentation verifying required training as set forth in subrule 110.5(11).

c. An individual file for each staff assistant that contains:

(1) A completed Form 595-1396, DHS Criminal History Record Check.

(2) A completed Form 470-0643, Request for Child Abuse Information.

(3) A physician's signed statement that meets the requirements of paragraph 110.5(2) "a."

(4) Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse completed within six months of employment and every five years thereafter, as required by Iowa Code section 232.69.

d. An individual file for each substitute that contains:

(1) A completed Form 595-1396, DHS Criminal History Record Check.

(2) A completed Form 470-0643, Request for Child Abuse Information.

(3) A physician's signed statement that meets the requirements of paragraph 110.5(2) "a."

(4) Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse completed within six months of employment and every five years thereafter, as required by Iowa Code section 232.69.

(5) Certification in first aid that meets the requirements of subparagraph 110.5(2) "b"(2).

110.5(3) Activity program. There shall be an activity program which promotes self-esteem and exploration and includes:

a. Active play.

b. Quiet play.

c. Activities for large muscle development.

d. Activities for small muscle development.

e. Play equipment and materials in a safe condition, for both indoor and outdoor activities which are developmentally appropriate for the ages and number of children present.

110.5(4) The certificate of registration shall be displayed in a conspicuous place.

110.5(5) Parental access. Parents shall be afforded unlimited access to their children and to the people caring for their children during the normal hours of operation or whenever their children are in the care of the child development home, unless parental contact is prohibited by court order.

110.5(6) Discipline. Discipline shall conform to the following standards:

a. Corporal punishment including spanking, shaking and slapping shall not be used.

b. Punishment which is humiliating or frightening or which causes pain or discomfort to the child shall not be used.

c. Punishment shall not be administered because of a child's illness, or progress or lack of progress in toilet training, nor shall punishment or threat of punishment be associated with food or rest.

d. No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

e. Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

110.5(7) Meals. Regular meals and midmorning and midafternoon snacks shall be provided which are well-balanced, nourishing, and in appropriate amounts as defined by the USDA Child and Adult Care Food Program. Children may bring food to the child development home for their own consumption, but shall not be required to provide their own food.

110.5(8) Children's files. An individual file shall be maintained for each child and updated annually or when the provider becomes aware of changes. The file shall contain:

a. Identifying information including, at a minimum, the child's name, birth date, parent's name, address, telephone number, special needs of the child, and the parent's work address and telephone number.

b. Emergency information including, at a minimum, where the parent can be reached, the name, street address, city and telephone number of the child's regular source of health care, and the name, telephone number, and relationship to the child of another adult available in case of emergency.

c. A signed medical consent from the parent authorizing emergency treatment.

d. An admission physical examination report signed by a licensed physician or designee in a clinic supervised by a licensed physician.

(1) The date of the physical examination shall not be more than 12 months before the child's first day of attendance at the child development home.

(2) The written report shall include past health history, status of present health, allergies and restrictive conditions, and recommendations for continued care when necessary.

(3) For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physical examination report.

(4) The examination report or statement of health status shall be on file before the child's first day of care.

e. A statement of health condition signed by a physician or designee submitted annually from the date of the admission physical. For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physician statement.

f. A list signed by the parent which names persons authorized to pick up the child. The authorization shall include the name, telephone number, and relationship of the authorized person to the child.

g. A signed and dated immunization certificate provided by the state department of public health. For the school-age child, a copy of the most recent immunization record shall be acceptable.

h. For each school-age child, on the first day of attendance, documentation of a physical examination that was completed at the time of school enrollment or since.

i. Written permission from the parent for the child to attend activities away from the child development home. The permission shall include:

(1) Times of departure and arrival.

(2) Destination.

(3) Persons who will be responsible for the child.

j. Injury report forms documenting injuries requiring first aid or medical care.

110.5(9) Provider. The provider shall meet the following requirements:

a. Give careful supervision at all times.

b. Exchange information with the parent of each child frequently to enhance the quality of care.

c. Give consistent, dependable care and be capable of handling emergencies.

d. Be present at all times except when emergencies occur or an absence is planned, at which time care shall be provided by a department-approved substitute. When an absence is planned, the provider shall give parents at least 24 hours' prior notice.

110.5(10) Substitutes. The provider shall assume responsibility for providing adequate and appropriate supervision at all times when children are in attendance. Any designated substitute shall have the same responsibility for providing adequate and appropriate supervision. Ultimate responsibility for supervision shall be with the provider.

a. All standards in this chapter regarding supervision and care of children shall apply to substitutes.
b. Except in emergency situations, the provider shall inform parents in advance of the planned use of a substitute.

c. The substitute must be 18 years of age or older.

d. Use of a substitute shall be limited to:

(1) No more than 25 hours per month.

(2) An additional period of up to two weeks in a 12-month period.

e. The provider shall maintain a written record of the number of hours substitute care is provided, including the date and the name of the substitute.

110.5(11) Professional development.

a. The provider shall receive two hours of Iowa's training for mandatory reporting of child abuse:

(1) During the first three months of registration as a child development home; and

(2) Every five years thereafter.

b. The provider shall obtain first-aid training within the first three months of registration as a child development home.

(1) First-aid training shall be provided by a nationally recognized training organization, such as the American Red Cross, the American Heart Association, the National Safety Council, or Emergency Medical Planning (Medic First Aid) or by an equivalent trainer using curriculum approved by the department.

(2) First-aid training shall include certification in infant and child first aid that includes management of a blocked airway and mouth-to-mouth resuscitation.

(3) The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.

c. During the first year of registration, the provider shall receive a minimum of 12 hours of training from one or more of the following content areas. The provider shall receive at least 6 of these hours in a group setting as defined in subrule 110.5(12), and 2 of the hours must be from the content area in subparagraph 110.5(11)"c"(1). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(1) Planning a safe, healthy learning environment (includes nutrition).

(2) Steps to advance children's physical and intellectual development.

(3) Positive ways to support children's social and emotional development (includes guidance and discipline).

(4) Strategies to establish productive relationships with families (includes communication skills and cross-cultural competence).

(5) Strategies to manage an effective program operation (includes business practices).

(6) Maintaining a commitment to professionalism.

(7) Observing and recording children's behavior.

(8) Principles of child growth and development.

d. During the second year of registration and each succeeding year, the provider shall receive a minimum of 12 hours of training from one or more of the content areas as defined in paragraph "c." The provider shall receive at least 6 of these hours in a group setting as defined in subrule 110.5(12). The provider may receive the remaining hours in self-study as defined in subrule 110.5(13). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

e. A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC), ChildNet, or Beyond Business Basics training series may use those hours to fulfill a maximum of two years' training requirements, not including first-aid and mandatory reporter training.

110.5(12) Group training. Training received in a group setting is not self-study, but is training received with other adults.

a. The training must be conducted by a trainer who is employed by or under contract with one of the following entities or who uses curriculum or training materials developed by or obtained with the written permission of one of the following entities:

- (1) An accredited university or college.
- (2) A community college.
- (3) Iowa State University Extension.
- (4) A child care resource and referral agency.
- (5) An area education agency.
- (6) The regents' center for early developmental education at the University of Northern Iowa.
- (7) A hospital (for health and safety, first-aid, and CPR training).
- (8) The American Red Cross, the American Heart Association, the National Safety Council, or Medic First Aid (for first-aid and CPR training).
- (9) An Iowa professional association, including the Iowa Association for the Education of Young Children (Iowa AEYC), the Iowa Family Child Care Association (IFCCA), the Iowa After School Alliance, and the Iowa Head Start Association.
- (10) A national professional association, including the National Association for the Education of Young Children (NAEYC), the National Child Care Association (NCCA), the National Association for Family Child Care (NAFCC), the National After School Association, and the American Academy of Pediatrics.
- (11) The Child and Adult Care Food Program and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
- (12) The Iowa department of public health, department of education, or department of human services.
- (13) Head Start agencies or the Head Start technical assistance system.

b. Training received in a group setting must follow a presentation format that incorporates a variety of adult learning methods. The material or content of the training must be obtained from one of the entities listed in paragraph "a" or an entity approved under paragraph "g." Approved training shall be made available to Iowa child care providers through the child care provider training registry beginning July 1, 2009.

c. Training received in a group setting may include distance learning opportunities such as training conducted over the Iowa communications network, on-line courses, or Web conferencing (webinars) if:

- (1) The training meets the requirements in subrule 110.5(14);
- (2) The training is taught by an instructor and requires interaction between the instructor and the participants, such as required chats or message boards; and
- (3) The training organization meets the requirements listed in this subrule or is approved by the department.

d. The department will not approve more than eight hours of training delivered in a single day.

e. The department may randomly monitor any state-approved training for quality control purposes.

f. Training conducted with staff either during the hours of operation of the facility, staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff shall not be actively engaged in care and supervision and simultaneously participate in training.

g. A training organization not approved by the department may submit training for approval to the department on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

110.5(13) Self-study training. Up to six hours of training may be received in self-study using a training package approved by the department.

a. Self-study training packages approved by the department include curriculum developed and materials distributed by:

- (1) Department child care licensing consultants,
- (2) Iowa State University Extension, or
- (3) A child care resource and referral agency.

b. Self-study training materials not distributed by these entities may be submitted by the training organization to the department for approval on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

110.5(14) Approved training. Training provided to Iowa child care providers shall offer:

a. Instruction that is consistent with:

- (1) Iowa child care regulatory standards;
- (2) The Iowa early learning standards; and
- (3) The philosophy of developmentally appropriate practice as defined by the National Association for the Education of Young Children, the Program for Infant/Toddler Care, and the National Health and Safety Performance Standards.

b. Content equal to at least one contact hour of training.

c. An opportunity for ongoing interaction and timely feedback, including questions and answers within the contact hours if training is delivered in a group setting.

d. A certificate of training for each participant that includes:

- (1) The name of the participant.
- (2) The title of the training.
- (3) The dates of training.
- (4) The content area addressed.
- (5) The name of the training organization.
- (6) The name of the instructor.
- (7) The number of contact hours.
- (8) An indication of whether the training was delivered through self-study or in a group setting.

[ARC 8098B, IAB 9/9/09, effective 11/1/09; ARC 0666C, IAB 4/3/13, effective 6/1/13]

441—110.6(237A) Compliance checks. During a calendar year, the department shall check 20 percent or more of all child development homes in each county for compliance with registration requirements. Completed evaluation checklists shall be placed in the registration files.

441—110.7(234) Registration decision. The department shall issue Form 470-3498, Certificate of Registration, when an applicant meets all requirements for registration. Each local office of the department shall maintain a current list of registered child development homes as a referral service to the community.

110.7(1) Registration shall be denied or revoked if the department finds a hazard to the safety and well-being of a child and the provider cannot correct or refuses to correct the hazard, even though the hazard may not have been specifically listed under the health and safety rules. Registration may also be denied or revoked if the department determines that the provider has failed to comply with standards imposed by law and these rules.

110.7(2) Record shall be kept in an open file of all denials or revocations of registration and the documentation of reasons for denying or revoking the registration.

110.7(3) Record checks. The department shall submit record checks in Iowa for each registrant, substitute, and staff member, and for anyone living in the home who is 14 years of age or older and anyone having access to a child when the child is alone. The purpose of these record checks is to determine whether the person has committed a transgression. The department may use Form 470-0643, Request for Child Abuse Information, and Form 595-1396, DHS Criminal History Record Check, Form

B, or any other form required for criminal and child abuse record checks. The department may also conduct criminal and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or in other states.

a. Mandatory prohibition. A person with the following convictions or founded abuse reports is prohibited from involvement with child care:

- (1) Founded child or dependent adult abuse that was determined to be sexual abuse.
- (2) Placement on the sex offender registry.
- (3) Felony child endangerment or neglect or abandonment of a dependent person.
- (4) Felony domestic abuse.
- (5) Felony crime against a child including, but not limited to, sexual exploitation of a minor.
- (6) Forcible felony.

b. Mandatory time-limited prohibition.

(1) A person with the following convictions or founded abuse reports is prohibited from involvement with child care for five years from the date of the conviction or founded abuse report:

1. Conviction of a controlled substance offense under Iowa Code chapter 124.
2. Founded child abuse that was determined to be physical abuse.

(2) After the five-year prohibition period from the date of the conviction or the founded abuse report as defined in subparagraph 110.7(3)“b”(1), the person may request the department to perform an evaluation under paragraph 110.7(3)“c” to determine whether prohibition of the person’s involvement with child care continues to be warranted.

c. Evaluation required. For all other transgressions, the department shall deny or revoke the registration, unless an evaluation of the transgression determines that the transgression does not warrant prohibition of involvement with child care.

(1) In an evaluation, the department shall consider all of the following factors:

1. The nature and seriousness of the transgression.
2. The time elapsed since the transgression.
3. The circumstances under which the transgression was committed.
4. The degree of rehabilitation.
5. The likelihood that the person will commit the transgression again.
6. The number of transgressions committed by the person.

(2) The person with the transgression shall complete and return Form 470-2310, Record Check Evaluation, to be used to assist in the evaluation. Failure of the person to complete and return the form within ten calendar days of the date on the form shall result in denial or revocation of the registration certificate.

(3) The department may use information from the department’s case records in performing the evaluation.

(4) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person’s involvement with child care and has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department’s previous evaluation. The exemption is subject to all of the following conditions:

1. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

2. Any restrictions placed on the person’s employment by the department in the previous evaluation shall remain applicable in the person’s subsequent employment.

3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer or the previous employer provides to the subsequent employer the previous evaluation from the person’s personnel file pursuant to the person’s authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.

4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

d. Evaluation decision. The department has final authority in determining whether prohibition of the person's involvement with child care is warranted and in developing any conditional requirements and a corrective action plan. The evaluation and decision shall be made by the service area manager or designee.

(1) Within 30 days of receipt of the completed Form 470-2310, the department shall mail to the person subject to an evaluation and to the registrant for an employee of the registrant Form 470-2386, Record Check Decision, that explains the decision reached regarding the evaluation of the transgression. The department shall also issue Form 470-2386 when the person subject to an evaluation fails to complete the evaluation form within the ten-calendar-day time frame.

(2) If the department determines, through the record check evaluation, that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care.

(3) The department may permit a person who is evaluated to be involved with child care if the person complies with the department's conditions relating to the person's involvement with child care, which may include completion of additional training. For an employee of a registrant, these conditional requirements shall be developed with the registrant.

110.7(4) Letter of revocation. A letter received by an owner or operator of a child development home initiating action to deny or revoke the home's registration shall be conspicuously posted where it can be read by parents or any member of the public. The letter shall remain posted until resolution of the action to deny or revoke an owner's or operator's certificate of registration.

110.7(5) If the department has denied or revoked a registration because the provider has continually or repeatedly failed to operate in compliance with Iowa Code chapter 237A and 441—Chapter 110, the person shall not own or operate a registered facility for a period of 12 months from the date of denial or revocation. The department shall not act on an application for registration submitted by the applicant or provider during the 12-month period. The applicant shall be prohibited from involvement with child care unless the department specifically permits the involvement.

[ARC 0418C, IAB 10/31/12, effective 1/1/13]

441—110.8(237A) Additional requirements for child development home category A. In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category A shall meet the following standards:

110.8(1) Limits on number of children in care.

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, not more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than two children who attend school may be present for a period of less than two hours at a time.

d. No more than eight children shall be present at any one time when an emergency school closing is in effect.

110.8(2) Provider qualifications.

a. The provider shall be at least 18 years old.

b. The provider shall have three written references which attest to character and ability to provide child care.

441—110.9(237A) Additional requirements for child development home category B. In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category B shall meet the following standards:

110.9(1) Limits on number of children in care.

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, not more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than four children who attend school may be present.

d. In addition to these ten children, no more than two children who are receiving care on a part-time basis may be present.

e. No more than 12 children shall be present at any one time when an emergency school closing is in effect.

f. If more than eight children are present at any one time for a period of more than two hours, the provider shall be assisted by a department-approved assistant who is at least 14 years old.

110.9(2) Provider qualifications.

a. The provider shall be at least 20 years old.

b. The provider shall have a high school diploma or GED.

c. The provider shall either:

(1) Have two years of experience as a registered or nonregistered child care provider, or

(2) Have a child development associate credential or any two-year or four-year degree in a child-care-related field and one year of experience as a registered or nonregistered child care home provider.

110.9(3) Facility requirements.

a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.

b. The home shall have a separate quiet area for sick children.

c. The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor shall not be permitted for child care.

441—110.10(237A) Additional requirements for child development home category C. In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category C shall meet the following standards:

110.10(1) Limits on number of children in care.

a. No more than 12 children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these 12 children, not more than 4 children who are 24 months of age or younger shall be present at any one time. Whenever 4 children who are under the age of 18 months are in care, both providers shall be present.

c. In addition to the 12 children not in school, no more than 2 children who attend school may be present for a period of less than two hours at any one time.

d. In addition to these 14 children, no more than 2 children who are receiving care on a part-time basis may be present.

e. No more than 16 children shall be present at any one time when an emergency school closing is in effect. If more than 8 children are present at any one time due to an emergency school closing exception, the provider shall be assisted by a department-approved assistant who is at least 18 years of age.

f. If more than eight children are present, both providers shall be present. Each provider shall meet the provider qualifications for child development home category C.

110.10(2) Provider qualifications.

a. One provider who meets the following qualifications must always be present:

- (1) The provider shall be at least 21 years old.
 - (2) The provider shall have a high school diploma or GED.
 - (3) The provider shall either:
 1. Have five years of experience as a registered or nonregistered child care provider, or
 2. Have a child development associate credential or any two-year or four-year degree in a child care-related field and four years of experience as a registered or nonregistered child care home provider.
- b. The coprovider shall meet the requirements of subrule 110.9(2).

110.10(3) Facility requirements.

- a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.
- b. The home shall have a separate quiet area for sick children.
- c. The home shall have a minimum of two direct exits to the outside from the main floor.
- (1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.
 - (2) All exits shall terminate at grade level with permanent steps.
 - (3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.
 - (4) Occupancy above the second floor shall not be permitted for child care.

441—110.11(237A) Complaints. The department shall conduct an on-site visit when a complaint is received.

110.11(1) After each complaint visit, the department shall document whether the child development home was in compliance with registration requirements.

110.11(2) The written documentation of the department's conclusion as to whether the child development home was in compliance with requirements shall be available to the public. However, the identity of all complainants shall be confidential, unless expressly waived by the complainant.

441—110.12(237A) Registration actions for nonpayment of child support. The department shall revoke or deny the issuance or renewal of a child development home registration upon the receipt of a certificate of noncompliance from the child support recovery unit of the department according to the procedures in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code chapter 252J, the rules in this chapter shall apply.

110.12(1) Service of notice. The notice required by Iowa Code section 252J.8 shall be served upon the applicant or registrant by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rules of Civil Procedure 56.1. Alternatively, the applicant or registrant may accept service personally or through authorized counsel.

110.12(2) Effective date. The effective date of the revocation or denial of the registration as specified in the notice required by Iowa Code section 252J.8 shall be 60 days following service of the notice upon the applicant or licensee.

110.12(3) Preparation of notice. The department director or designee of the director is authorized to prepare and serve the notice as required by Iowa Code section 252J.8 upon the applicant or registrant.

110.12(4) Responsibilities of registrants and applicants. Registrants and registrant applicants shall keep the department informed of all court actions, and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J, and shall provide the department copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in the actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

110.12(5) District court. A registrant or applicant may file an application with the district court within 30 days of service of a department notice pursuant to Iowa Code sections 252J.8 and 252J.9.

a. The filing of the application shall stay the department action until the department receives a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed.

b. For purposes of determining the effective date of the revocation, or denial of the issuance or renewal of a registration, the department shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

110.12(6) Procedure for notification. The department shall notify the applicant or registrant in writing through regular first-class mail, or such other means as the department deems appropriate in the circumstances, within ten days of the effective date of the revocation of a registration or the denial of the issuance or renewal of a registration, and shall similarly notify the applicant or registrant when the registration is issued, renewed, or reinstated following the department's receipt of a withdrawal of the certificate of noncompliance.

110.12(7) Appeal rights. Notwithstanding Iowa Code section 17A.18, the registrant does not have the right to a hearing regarding this issue, but may request a court hearing pursuant to Iowa Code section 252J.9.

441—110.13(237A) Transition exception. The following transition exceptions shall apply to providers renewing a valid previously issued child care home registration on or after December 1, 2002:

110.13(1) If the provider is providing child care to four infants at the time of renewal, the provider may continue to provide child care to those four infants. However, when the provider no longer provides child care to one or more of the four infants, or one or more of the four infants reaches the age of 24 months, this exception shall no longer apply. This exception does not affect the overall limit on the number of children in care under the child development home category within which the provider is registered.

110.13(2) If the provider is providing child care to school-age children in excess of the number allowable for the provider's registration category at the time of renewal, the provider may continue to provide care to those children and may exceed the total number of children authorized for that category by the excess number of school-age children. This exception is subject to the following conditions:

- a.* The maximum number of children attributable to this exception is five.
- b.* The provider must comply with the other requirements limiting the number of children under that registration category.
- c.* If more than eight children are present at any one time for more than two hours, the provider shall be assisted by a department-approved assistant who is at least 14 years of age.
- d.* When the provider no longer provides child care to one or more of the school-age children who was receiving child care at the time of registration, the excess number of children allowed under this exception shall be reduced accordingly.

441—110.14(237A) Prohibition from involvement with child care. If the department has prohibited a person or program from involvement with child care, that person or program shall not provide child care as a nonregistered child care home provider.

These rules are intended to implement Iowa Code section 234.6 and chapter 237A.

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CHAPTER 57
RESIDENTIAL CARE FACILITIES
[Prior to 7/15/87, Health Department[470] Ch 57]

481—57.1(135C) Definitions. For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words “shall” and “must” indicate those standards are mandatory. The use of the words “should” and “could” indicate those standards are recommended.

57.1(1) “*Accommodation*” means the provision of lodging, including sleeping, dining, and living areas.

57.1(2) “*Administrator*” means a person approved and certified by the department who administers, manages, supervises, and is in general administrative charge of a residential care facility, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

57.1(3) “*Alcoholic*” means a person in a state of dependency resulting from excessive or prolonged consumption of alcoholic beverages as defined in Iowa Code section 125.2.

57.1(4) “*Ambulatory*” means the condition of a person who immediately and without aid of another is physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

57.1(5) “*Basement*” means that part of a building where the finish floor is more than 30 inches below the finish grade of the building.

57.1(6) “*Board*” means the regular provision of meals.

57.1(7) “*Communicable disease*” means a disease caused by the presence of viruses or microbial agents within a person’s body, which agents may be transmitted either directly or indirectly to other persons.

57.1(8) “*Department*” means the state department of inspections and appeals.

57.1(9) “*Distinct part*” means a clearly identifiable area or section within a health care facility, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

57.1(10) “*Drug addiction*” means a state of dependency, as medically determined, resulting from excessive or prolonged use of drugs as defined in Iowa Code chapter 204.

57.1(11) “*Medication*” means any drug including over-the-counter substances ordered and administered under the direction of the physician.

57.1(12) “*Nonambulatory*” means the condition of a person who immediately and without aid of another is not physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

57.1(13) “*Personal care*” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are help in getting in and out of bed, assistance with personal hygiene and bathing, help with dressing and feeding, and supervision over medications which can be self-administered.

57.1(14) “*Program of care*” means all services being provided for a resident in a health care facility.

57.1(15) “*Qualified mental retardation professional*” means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and having one year’s experience working with the mentally retarded.

57.1(16) “*Rate*” means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these rules and regulations.

57.1(17) “*Responsible party*” means the person who signs or cosigns the admission agreement required in 481—57.14(135C) or the resident’s guardian or conservator if one has been appointed. In the event that a resident has neither a guardian, conservator nor person who signed or cosigned the resident’s admission agreement, the term “responsible party” shall include the resident’s sponsoring agency, e.g., the department of social services, veteran’s administration, religious groups, fraternal

organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

57.1(18) “*Restraints*” means the measures taken to control a resident’s physical activity for the resident’s own protection or for the protection of others.

481—57.2(135C) Variances. Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual residential care facility. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

57.2(1) To request a variance, the licensee must:

- a. Apply for variance in writing on a form provided by the department of inspections and appeals;
- b. Cite the rule or rules from which a variance is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain alternate arrangements or compensating circumstances which justify the variance;
- e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

57.2(2) Upon receipt of a request for variance, the director of the department of inspections and appeals will:

- a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;
- b. If the request meets the above criteria, evaluate the alternate arrangements of compensating circumstances against the requirement of the rules;
- c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;
- d. Consult with the applicant if additional information is required.

57.2(3) Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

481—57.3(135C) Application for licensure.

57.3(1) Initial application and licensing. In order to obtain an initial residential care facility license for a residential care facility which is currently licensed the applicant must:

- a. Meet all of the rules, regulations, and standards contained in 481—Chapters 57 and 60;
- b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;
- c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;
- d. Submit a floor plan of each floor of the facility drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door location;
- e. Submit a photograph of the front and side elevation of the facility;
- f. Submit the statutory fee for a residential care facility license;
- g. Comply with all other local statutes and ordinances in existence at the time of licensure;
- h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

57.3(2) In order to obtain an initial residential care facility license for a facility not currently licensed as a residential care facility, the applicant must:

- a. Meet all of the rules, regulations, and standards contained in 481—Chapters 57 and 60. Exceptions noted in 481—subrule 60.3(2) shall not apply;
- b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

- c. Make application at least 30 days prior to the proposed opening date of the facility on forms provided by the department;
- d. Submit a floor plan of each floor of the residential care facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door locations;
- e. Submit a photograph of the front and side of the residential care facility;
- f. Submit the statutory fee for a residential care facility license;
- g. Comply with all other local statutes and ordinances in existence at the time of licensure;
- h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

57.3(3) Renewal application. In order to obtain a renewal of the residential care facility license, the applicant must:

- a. Submit the completed application form 30 days prior to annual license renewal date of residential care facility license;
- b. Submit the statutory license fee for a residential care facility with the application for renewal;
- c. Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;
- d. Submit appropriate changes in the résumé to reflect any changes in the resident care program or other services.

57.3(4) Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

481—57.4(135C) Special categories. Special variations and considerations may be granted a residential care facility which is operated for people who have special problems such as retardation, physical disabilities, have a physical or mental disability or a condition in common which can best be treated in a specialized environment under an approved program of care commensurate with the needs of the residents of the facility. Criteria for these specialized programs shall be established by the department based on the résumé of programs and services furnished by the facility and the numbers and qualifications of the administrator and staff providing these services in the facility.

57.4(1) Such a facility shall be provided with the kind of equipment, numbers of qualified staff, and operated in such fashion as to meet the requirements of the department.

57.4(2) On approval of the department, the state fire marshal, the department of social services, or other appropriate agencies, other variations from the established rules and regulations and standards for a licensed health care facility of that category may be made as is necessary to successfully implement the specialized program, providing that it does not endanger the health, safety, or welfare of any resident and that alternate means to effect the same degree of protection shall be used when such variances are permitted.

481—57.5(135C) General requirements.

57.5(1) The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

57.5(2) The license shall be valid only in the possession of the licensee to whom it is issued.

57.5(3) The posted license shall accurately reflect the current status of the residential care facility. (III)

57.5(4) Licenses expire one year after the date of issuance or as indicated on the license.

57.5(5) Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

481—57.6(135C) Notifications required by the department. The department shall be notified:

57.6(1) Within 48 hours, by letter, of any reduction or loss of personal care or dietary staff lasting more than seven days which places the staffing ratio below that required for licensing. No additional residents may be admitted until the minimum staffing requirements are achieved; (III)

57.6(2) Of any proposed change in the residential care facility's functional operation or addition or deletion of required services; (III)

57.6(3) Thirty days before addition, alteration, or new construction is begun in the residential care facility or on the premises; (III)

57.6(4) Thirty days in advance of closure of the residential care facility; (III)

57.6(5) Within two weeks of any change in administrator; (III)

57.6(6) When any change in the category of license is sought; (III)

57.6(7) Prior to the purchase, transfer, assignment, or lease of a residential care facility, the licensee shall:

a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)

b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease if completed; (III)

c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's residential care facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

57.6(8) Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a residential care facility, the department shall upon request send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

481—57.7(135C) Witness fees. Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

481—57.8(135C) Licenses for distinct parts.

57.8(1) Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

57.8(2) The following requirements shall be met for a separate licensing of a distinct part:

a. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)

b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

c. The distinct part must be operationally and financially feasible;

d. A separate personal care staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)

e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry and dietary in common with each other.

481—57.9(135C) Administrator. Each residential care facility shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. (III)

57.9(1) The administrator shall be at least 18 years of age and shall have a high school diploma or equivalent. (III) In addition, this person shall meet at least one of the following conditions:

a. Be a licensed nursing home administrator; or (III)

b. Have completed a one-year educational training program approved by the department for residential care facility administrators; or (III)

c. Have two years of supervised experience in a residential care facility, at least six months of which was in an administrative capacity. (III)

57.9(2) The administrator may act as an administrator for not more than two residential care facilities. (II)

a. The distance between the two facilities shall be no greater than 50 miles. (II)

b. The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)

c. The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

57.9(3) The licensee may be the approved administrator providing the licensee meets the requirements set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

57.9(4) A provisional administrator may be appointed on a temporary basis by the residential care facility licensee to assume the administrative responsibilities for a residential care facility for a period not to exceed six months when, through no fault of its own, the home has lost its administrator and has not been able to replace the administrator provided the department has been notified prior to the date of the administrator's appointment. (III)

57.9(5) In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

a. Be knowledgeable of the operation of the facility; (III)

b. Have access to records concerned with the operation of the facility; (III)

c. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)

d. Be at least 18 years of age; (III)

e. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)

f. Have had training to carry out assignments and take care of emergencies and sudden illnesses of residents. (III)

57.9(6) An administrator of only one facility shall be considered as a full-time employee. Full-time employment is defined as 40 hours per week. (III)

481—57.10(135C) Administration.

57.10(1) The licensee shall:

a. Assume the responsibility for the overall operation of the residential care facility; (III)

b. Be responsible for compliance with all applicable laws and with the rules of the department; (III)

c. Establish written policies, which shall be available for review, for the operation of the residential care facility. (III)

57.10(2) The administrator shall:

a. Be responsible for the selection and direction of competent personnel who provide services for the resident care program; (III)

b. Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)

c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)

d. Make available the residential care facility payroll records for departmental review as needed. (III)

481—57.11(135C) General policies.

57.11(1) There shall be written personnel policies in facilities of more than 15 beds to include hours of work and attendance at educational programs. (III)

57.11(2) There shall be a written job description developed for each category of worker in facilities of more than 15 beds. The job description shall include title of job, job summary, age range, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

57.11(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

- a. Employees shall have a physical examination before employment. (I, II, III)
- b. Employees shall have a physical examination at least every four years. (I, II, III)
- c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

57.11(4) Health certificates for all employees shall be available for review. (III)

57.11(5) Rescinded IAB 10/19/88, effective 11/23/88.

57.11(6) There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident, which includes the individuals to be contacted in case of emergency. (III)

57.11(7) The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

57.11(8) The residential care facility shall have established policies concerning the control, investigation, and prevention of infections within the facility. (III)

57.11(9) Each facility licensed as a residential care facility shall provide an organized continuous 24-hour program of care commensurate with the needs of the residents of the home and under the direction of an administrator whose combined training and supervisory experience is such as to ensure adequate and competent care. (III)

57.11(10) Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

57.11(11) Each facility shall have a written and implemented infection control program addressing the following:

a. Techniques for hand washing consistent with Guidelines for Handwashing and Hospital Control, 1985, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923404; (I, II, III)

b. Techniques for handling of blood, body fluids, and body wastes consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

c. Dressings, soaks, or packs; (I, II, III)

d. Infection identification; (I, II, III)

e. Resident care procedures to be used when there is an infection present consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

f. Sanitation techniques for resident care equipment; (I, II, III)

g. Techniques for sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags; (I, II, III)

h. Techniques for use and disposal of needles, syringes, and other sharp instruments consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

CDC Guidelines may be obtained from the U.S. Department of Commerce, Technology Administration, National Technical Information Service, 5285 Port Royal Rd., Springfield, Virginia 22161 (1-800-553-6847).

57.11(12) Aseptic techniques. If a resident needs any of the treatment or devices on the list below, written and implemented procedures regarding aseptic techniques shall be followed.

- a. Intravenous or central line catheter consistent with Guideline for Prevention of Intravascular Device Related Infections, Centers for Disease Control, U.S. Department of Health and Human Services, PB97-130074, (I, II, III)
- b. Urinary catheter, (I, II, III)
- c. Respiratory suction, oxygen or humidification, (I, II, III)
- d. Decubitus care, (I, II, III)
- e. Tracheostomy, (I, II, III)
- f. Nasogastric or gastrostomy tubes, (I, II, III)
- g. Sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags. (I, II, III)

[ARC 0663C, IAB 4/3/13, effective 5/8/13]

481—57.12(135C) Personnel.

57.12(1) General qualifications.

- a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a residential care facility. (II)
- b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a residential care facility. (II)
- c. No person shall be allowed to provide services in a facility if the person has a disease;
 - (1) Which is transmissible through required workplace contact, (I, II, III)
 - (2) Which presents a significant risk of infecting others, (I, II, III)
 - (3) Which presents a substantial possibility of harming others, and (I, II, III)
 - (4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

- d. Reserved.
- e. Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

57.12(2) Supervision and staffing.

- a. Staffing.
 - (1) In a facility that is licensed for more than one level of care, where the facility consists of a single building or of contiguous buildings, the department shall establish on an individual facility basis the numbers and qualifications of the staff required in a residential care facility, based on the needs of the residents in that facility.
 - (2) In a facility licensed only for residential care the facility shall provide the following minimum staffing ratios of personal care staff:
 - Days—1:25 or less (II, III)
 - Evenings—1:35 or less (II, III)
 - Nights—1:45 or less (II, III)
 Additional staffing above the minimum ratio may be required by the department commensurate with the needs of individual residents.

b. Personnel in a residential care facility shall provide 24-hour coverage for residential care services. Personnel shall be up and dressed at all times in facilities over 15 beds. (II, III)

c. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. (II, III)

d. Physician's orders shall be implemented by qualified personnel. (II, III)

57.12(3) Personnel histories.

a. Each health care facility shall submit a form specified by the department of public safety to the department of public safety, and receive the results of a criminal history check and dependent adult abuse record check before any person is employed in a health care facility. The health care facility may submit a form specified by the department of human services to the department of human services to request a child abuse history check. For the purposes of this subrule, "employed in a facility" shall

be defined as any individual who is paid, either by the health care facility or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors), to provide direct or indirect treatment or services to residents in a health care facility. 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 requirements of this subrule are individuals such as building contractors, repair workers or others who are in a facility for a very limited purpose, are not in the facility on a regular basis, and who do not provide any treatment or services to the residents of the health care facility. (I, II, III)

b. A person who has a criminal record or founded dependent adult abuse report cannot be employed in a health care facility unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse report does not merit prohibition from employment. (I, II, III)

c. Each health care facility shall ask each person seeking employment in a facility “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of crime in this state or any other state?” The person shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The person shall indicate, by signature, that the person has been informed that the record checks will be conducted. (I, II, III)

d. If a person has a record of founded child abuse in Iowa or any other state, the person shall not be employed in a health care facility unless the department of human services has evaluated the crime or founded report and concluded that the report does not merit prohibition of employment. (I, II, III)

e. Proof of dependent adult abuse and criminal history checks may be kept in files maintained by the temporary employee agencies and contractors. Facilities may require temporary agencies and contractors to provide a copy of the results of the dependent adult abuse and criminal history checks. (I, II, III)

481—57.13(135C) Admission, transfer, and discharge.

57.13(1) General admission policies.

a. No resident shall be admitted to or retained in a residential care facility who is in need of greater services than the facility can provide. (II, III)

b. No residential care facility shall admit more residents than the number of beds for which it is licensed. (II, III)

c. There shall be no more beds erected than is stipulated on the license. (II, III)

d. There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

e. The admission of a resident to a residential care facility shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident’s legal representative. (III)

f. The admission of a resident shall not grant the residential care facility the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and safe and orderly management of the residential care facility as required by these rules. (III)

g. A residential care facility shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

h. Rescinded, effective 7/14/82.

i. Funds or properties received by the residential care facility, belonging to or due a resident, expendable for the resident’s account, shall be trust funds. (III)

j. Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or

applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

k. No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity. (III)

l. Upon the verified petition of the county board of supervisors, the district court may appoint the administrator of a county care facility as conservator or guardian or both of a resident of such county care facility. Such administrator shall serve as conservator or guardian or both without fee. The administrator may establish either separate or common bank accounts for cash funds of such resident wards. (III)

57.13(2) Discharge or transfer.

a. Prior notification shall be made to the next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

b. Proper arrangements shall be made by the residential care facility for the welfare of the resident prior to the transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

c. The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such transfer or discharge. (II, III)

d. Advance notification by telephone will be made to the receiving facility prior to the transfer of any resident. (III)

e. When a resident is transferred or discharged, the appropriate record as set forth in 57.16(1) will accompany the resident. (II, III)

f. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

481—57.14(135C) Contracts. Each contract shall:

57.14(1) State the base rate or scale per day or per month, the services included, and the method of payment; (III)

57.14(2) Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. (III) Furthermore, the contract shall:

a. Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in subsection 2; (III)

b. State the method of payment of additional charges; (III)

c. Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

d. State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc. (III)

57.14(3) Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the program assessment at the time of admission, which is determined in consultation with the administrator; (III)

57.14(4) Include the total fee to be charged initially to the specific resident; (III)

57.14(5) State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

a. Written notification to the resident, or the responsible party when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to the effective date of such changes; (III)

b. Notification to the resident, or responsible party when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must be also given within a reasonable time, not to exceed one week, listing specifically the adjustments made. (III)

57.14(6) State the terms of agreement in regard to refund of all advance payments, in the event of transfer, death, voluntary, or involuntary discharge; (III)

57.14(7) State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party.

a. The facility shall ask the resident or responsible party if they want the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

b. The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

57.14(8) State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

57.14(9) State the conditions of voluntary discharge or transfer; (III)

57.14(10) Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter; (III)

57.14(11) Each party shall receive a copy of the signed contract. (III)

481—57.15(135C) Physical examinations.

57.15(1) Each resident in a residential care facility shall have a designated licensed physician, who may be called when needed. (III)

57.15(2) Each resident admitted to a residential care facility shall have had a physical examination prior to admission. (II, III)

a. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be a part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (II, III)

b. The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, physical examination, diagnosis, statement of chief complaints, and results of any diagnostic procedures. (II, III)

c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

57.15(3) Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

57.15(4) Rescinded, effective 7/14/82.

57.15(5) The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

57.15(6) Each resident shall be visited by or shall visit the resident's physician at least once each year. The year period shall be measured from the date of admission and is not to include preadmission physicals. Any required physician task or visit in a residential care facility may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with the physician. (III)

57.15(7) Residents shall be admitted to a residential care facility only on a written order signed by a physician certifying that the individual being admitted requires no more than personal care and supervision but does not require nursing care. (III)

This rule is intended to implement Iowa Code section 135C.23(2).
[ARC 0663C, IAB 4/3/13, effective 5/8/13]

481—57.16(135C) Records.

57.16(1) *Resident record.* The licensee shall keep a permanent record on all residents admitted to a residential care facility with all entries current, dated, and signed. (III) The record shall include:

- a. Name and previous address of resident; (III)
- b. Birth date, sex, and marital status of resident; (III)
- c. Church affiliation; (III)
- d. Physician's name, telephone number, and address; (III)
- e. Dentist's name, telephone number, and address; (III)
- f. Name, address, and telephone number of next of kin or legal representative; (III)
- g. Name, address, and telephone number of person to be notified in case of emergency; (III)
- h. Mortician's name, telephone number, and address; (III)
- i. Pharmacist's name, telephone number, and address; (III)
- j. Physical examination and medical history; (III)
- k. Certification by the physician that the resident requires no more than personal care and supervision, but does not require nursing care; (III)
- l. Physician's orders for medication, treatments, and diet in writing and signed by the physician quarterly; (III)
- m. A notation of yearly or other visits to physician or other professional services; (III)
- n. Any change in the resident's condition; (II, III)
- o. If the physician has certified that the resident is capable of taking prescribed medications, the resident shall be required to keep the administrator advised of current medications, treatments, and diet. The administrator shall keep a listing of medications, treatments, and diet prescribed by the physician for each resident; (III)
- p. If the physician has certified that the resident is not capable of taking prescribed medication, it must be administered by a qualified person of the facility. A qualified person shall be defined as either a registered or licensed practical nurse or an individual who has completed the state-approved training course in medication administration; (II)
- q. Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication; (II, III)
- r. A notation describing condition on admission, transfer, and discharge; (III)
- s. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)
- t. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)
- u. Disposition of valuables. (III)

57.16(2) Incident record.

- a. Each residential care facility shall maintain an incident record report and shall have available incident report forms. (III)
- b. Report of incidents shall be in detail on a printed incident report form. (III)
- c. The person in charge at the time of the incident shall oversee the preparation and sign the incident report. (III)
- d. The report shall cover all accidents whether there is apparent injury or where hidden injury may have occurred. (III)
- e. The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)
- f. A copy of the incident report shall be kept on file in the facility. (III)

57.16(3) Retention of records.

- a. Records shall be retained in the facility for five years following termination of services. (III)
- b. Records shall be retained within the facility upon change of ownership. (III)
- c. Rescinded, effective 7/14/82.
- d. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

57.16(4) Reports to the department. The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

57.16(5) Personnel record.

a. An employment record shall be kept for each employee consisting of the following information: Name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home, date and reason for discharge or resignation. (III)

b. The personnel records shall be made available for review upon request by the department. (III)

481—57.17(135C) Resident care and personal services.

57.17(1) Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

57.17(2) Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

57.17(3) Residents shall have clean clothing as needed to present a neat appearance, be free of odors, and to be comfortable. Clothing shall be appropriate to their activities and to the weather. (III)

57.17(4) Rescinded, effective 7/14/82.

57.17(5) Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

57.17(6) Residents shall not be required to pass through another's bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

57.17(7) Rescinded, effective 7/14/82.

57.17(8) Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

57.17(9) Residents shall be required to bathe at least twice a week. (II, III)

57.17(10) Nonambulatory residents.

a. All nonambulatory residents shall be housed on the grade level floor. (II)

b. These provisions in paragraph "a" above relating to nonambulatory residents are not applicable if the facility has a suitably sized elevator.

481—57.18 Rescinded, effective 7/14/82.

481—57.19(135C) Drugs.

57.19(1) Drug storage.

a. Residents who have been certified in writing by the physician as capable of taking their own medications, may retain these medications in their bedroom but locked storage must be provided. (III)

b. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

(1) A cabinet with a lock shall be provided which can be used for storage of drugs, solutions, and prescriptions; (III)

(2) A bathroom shall not be used for drug storage; (III)

(3) The drug storage cabinet shall be kept locked when not in use; (III)

(4) The drug storage cabinet key shall be in the possession of the employee charged with the responsibility of administering medications; (II)

(5) Schedule II drugs, as defined by Iowa Code chapter 204, shall be kept in a locked box within the locked medication cabinet; (II, III)

(6) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items; (III)

(7) Drugs for external use shall be stored separately from drugs for internal use; (III)

(8) All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons; (I, II)

(9) The drug cabinet shall have a work counter. Both the counter and cabinet shall be well-lighted; (III)

(10) Running water shall be available in the room in which the medicine cabinet is located or in an adjacent room; (III)

(11) Inspection of drug storage condition shall be made by the administrator and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician's order, and drugs improperly stored. (III)

(12) Double-locked storage of Schedule II drugs shall not be required under single-unit package drug distribution systems in which the quantity stored does not exceed a three-day supply and a missing dose can be readily detected. (II)

c. Bulk supplies of prescription drugs shall not be kept in a residential care facility unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

57.19(2) Drug safeguards.

a. All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III)

b. Medication containers having soiled, damaged, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

c. The medication for each resident shall be kept or stored in the original containers. (II, III)

d. When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

e. Unused prescription drugs prescribed for residents who have died shall be destroyed by the person in charge with a witness and notation made on the resident's record, or, if a unit dose system is used, such drugs shall be returned to the supplying pharmacist. (III)

f. Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

g. No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

h. Instructions shall be requested of the Iowa board of pharmacy examiners concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

i. There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by a responsible person with a witness and notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy examiners. (II, III)

j. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The personal physician of the resident, in conjunction with the pharmacist, shall institute these policies and provide procedures for review and endorsement. (II, III)

k. No resident shall be allowed to keep possession of any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

l. No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

m. Each facility shall establish a policy in conjunction with a licensed pharmacist to govern distributing prescribed medication to residents who are on leave from a facility. (III)

(1) Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 57.19(2)“a,” non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident’s name, the facility, the medication, its strength, dose, and time of administration.

(2) Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

(3) Medication distributed as above may be issued only by facility personnel responsible for administering medication.

57.19(3) Drug administration.

a. A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

b. The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

c. This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

d. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved residential aide course, nurse aide course, nurse aide training and testing program or nurse aide competency examination;

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

e. A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program’s pharmacology or clinical instructor indicating the individual is competent in medication administration.

f. A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph “d” of this subrule do not apply to this individual.

g. Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day that they are administered, (II) unless the unit dose system is used.

h. Injectable medications shall be administered by a qualified nurse or physician.

i. Residents certified by their physician as capable of injecting their own insulin may do so. Insulin may be administered pursuant to “h” above or as otherwise authorized by the resident’s physician. Authorization by the physician shall:

(1) Be in writing,

(2) Be maintained in the resident’s record,

(3) Be renewed quarterly,

(4) Include the name of the individual authorized to administer the insulin,

(5) Include documentation by the physician that the authorized person is qualified to administer insulin to that resident.

j. An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

k. The unit dose system may be used by the facility.

l. In a freestanding residential care facility licensed for 15 or fewer beds, a person who has successfully completed a state-approved medication manager course may administer medications.

481—57.20(135C) Dental services.

57.20(1) The residential care facility personnel shall assist residents to obtain regular and emergency dental services. (III)

57.20(2) Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)

57.20(3) Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)

57.20(4) All dental reports or progress notes shall be included in the clinical record. (III)

57.20(5) Personal care staff shall assist the resident in carrying out dentist's recommendations. (III)

57.20(6) Dentists shall be asked to participate in the in-service program of the facility. (III)

481—57.21(135C) Dietary.

57.21(1) *Dietary staffing.*

a. In facilities licensed for over 15 beds, persons in charge of meal planning and food preparation shall complete the home study course on sanitation and food preparation offered by the department. (III)

b. In facilities licensed for over 15 beds, food service personnel shall be on duty during a 12-hour span extending from the preparation of breakfast through supper. (III)

c. There shall be written work schedules and time schedules covering each type of job in the food service department. These work and time schedules shall be posted or kept in a notebook which is available for use in the food service area in facilities over 15 beds. (III)

57.21(2) *Nutrition and menu planning.*

a. Menus shall be planned and followed to meet nutritional needs of residents in accordance with the physician's orders. (II)

b. Menus shall be planned and served to include foods and amounts necessary to meet the recommended daily dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. (II) Recommended daily dietary allowances are:

(1) Milk - two or more cups served as beverage or used in cooking;

(2) Meat group - two or more servings of meat, fish, poultry, eggs, cheese or equivalent; at least four to five ounces edible portion per day;

(3) Vegetable and fruit group - four or more servings (two cups). This shall include a citrus fruit or other fruit and vegetable important for vitamin C daily, a dark green or deep yellow vegetable for vitamin A at least every other day, and other fruits and vegetables, including potatoes;

(4) Bread and cereal group - four or more servings of whole-grain, enriched or restored;

(5) Foods other than those listed will usually be included to meet daily energy requirements (calories) to add to the total nutrients and variety of meals.

c. At least three meals or their equivalent shall be served daily, at regular hours. (II)

(1) There shall be no more than a 14-hour span between substantial evening meal and breakfast. (II, III)

(2) To the extent medically possible, bedtime nourishments shall be offered routinely to all residents. Special nourishments shall be available when ordered by physician. (II, III)

d. Menus shall include a variety of foods prepared in various ways. The same menu shall not be repeated on the same day of the following week. (III)

e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing, and serving food. (III)

f. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

g. A file of tested recipes adjusted to the number of people to be fed in the facility shall be maintained. (III)

57.21(3) *Dietary storage, food preparation, and service.*

a. All food and drink shall be clean, wholesome, free from spoilage, and safe for human consumption. (II, III)

b. The use of foods from salvaged, damaged, or unlabeled containers shall be prohibited. (III)

c. All perishable or potentially hazardous food shall be stored at safe temperatures of 45°F (7°C) or below, or 140°F (60°C) or above. (III)

d. No perishable food shall be allowed to stand at room temperature any longer than is required to prepare and serve. (III)

e. Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a two-day period shall be maintained on the premises. Minimum food portion requirements for a low-cost plan shall conform to information supplied by the nutrition section of the department of health. (II, III)

f. Table service shall be attractive. Dishes shall be free of cracks, chips, and stains. (III)

g. If family-style service is used, all leftover prepared food that has been on the table shall be properly handled. (III)

h. Poisonous compounds shall not be kept in food storage or preparation areas. (II)

57.21(4) *Sanitation in food preparation area.*

a. "Food Service Sanitation Manual", revised 1976, U.S. Department of Health, Education, and Welfare, Public Health Service, U.S. Government Printing Office, Washington, D.C., shall be used as the established, nationally recognized reference for establishing and determining satisfactory compliance with food service sanitation.

b. Residents shall not be allowed in the food preparation area. (III)

c. In facilities licensed for over 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)

d. All foods, while being stored, prepared, displayed, served, or transported shall be protected against contamination from dust, flies, rodents, and other vermin. (II, III)

e. Food shall be protected from unclean utensils and worn surfaces, unnecessary handling, coughs and sneezes, flooding, drainage, and overhead leakage. (II, III)

f. All appliances and work areas shall be kept clean. (III)

g. There shall be written procedures established for cleaning all work and serving areas in facilities over 15 beds. (III)

h. A schedule for duties to be performed daily shall be posted in each food area. (III)

i. All cooking equipment in facilities of 15 or more beds shall be provided with a properly sized exhaust system and hood to eliminate excess heat, moisture, and odors from the kitchen. (III)

j. Spillage and breakage shall be cleaned up immediately. (III)

k. All garbage not mechanically disposed of shall be kept in nonabsorbent, cleanable containers pending disposal. All filled containers shall be covered and stored in a sanitary manner. (III)

l. The food service area shall be located so it will not be used as a passageway by residents, guests, or nonfood service staff. (III)

m. The walls, ceilings, and floors of all rooms in which food is prepared and served shall be in good repair, smooth, washable, and shall be kept clean. (III)

n. There shall be no washing, ironing, sorting or folding of laundry in the food service area. Dirty linen shall not be carried through the food service area unless it is in sealed, leakproof containers. (III)

- o.* Ice shall be stored and handled in such a manner as to prevent contamination. Ice scoops should be sanitized daily and kept in a clean container. (III)
- p.* There shall be no animals or birds in the food preparation area. (III)
- q.* No dishes or cooking utensils shall be towel dried. (III)
- r.* In facilities over 15 beds, a mechanical dishwasher is required. (III)
- s.* If there is a dishwashing machine, it must provide a wash temperature of 140°F (60°C) to 160°F (71°C) and a rinse temperature of 170°F (76°C) to 180°F (82°C). In a freestanding residential care facility licensed for 15 or fewer beds, a wash and rinse temperature of 140°F (60°C) to 160°F (71°C) shall be acceptable. (III)
- t.* A three-compartment pot and pan sink with 110°F (43°C) to 115°F (46°C) water for washing, a compartment for rinsing with water at 170°F (76°C) to 180°F (82°C) for sanitizing with space for air drying, or a two-compartment sink with access to a mechanical dishwasher for sanitizing all utensils shall be provided. (III)
- u.* All dishes, silverware, and cooking utensils shall be stored above the floor in a sanitary manner, in a clean, dry place protected from flies, splashes, dust, and other contaminants. (III)
- v.* Procedures for washing and handling dishes shall be followed in order to protect the welfare of the residents and employees. Persons handling dirty dishes shall not handle clean dishes without washing their hands. (III)
- w.* Dishes, silverware, and cooking utensils shall be properly cleaned by prerinsing or scraping, washing, sanitizing, and air-drying. (III)

57.21(5) Hygiene of food service personnel.

- a.* Food service personnel shall be free of communicable diseases and practice hygienic food-handling techniques. In the event food service employees are assigned duties outside the dietetic service, these duties shall not interfere with sanitation, safety, or time required for dietetic work assignments. Personnel recovering from a diagnosed intestinal infection shall submit a report from their physician showing freedom from infection before returning to work in the food service department. (II, III)
- b.* Employees shall wear clean, washable uniforms that are not used for duties outside the food service area. (III)
- c.* Hairnets shall be worn by all food service personnel. Individuals with beards shall provide for total enclosure of facial hair. (III)
- d.* Clean aprons and hairnets shall be available for use by other personnel in emergency situations. (III)
- e.* Persons handling food shall be knowledgeable of good hand-washing techniques. A hand-wash sink shall be provided in or adjacent to the food service area. Continuous on-the-job training on sanitation shall be encouraged. (III)
- f.* The use of tobacco shall be prohibited in the kitchen. (III)

57.21(6) Food and drink. All food and drink consumed within the facility shall be clean and wholesome and comply with local ordinances and applicable provisions of state and federal laws. (II, III)

481—57.22(135C) Service plan.

57.22(1) Prior to admission of a resident, the administrator or the administrator's designee shall develop a written and organized orientation plan. The plan shall be designed to assist the resident in adapting to the facility and to assist the facility staff in becoming knowledgeable of the resident and the resident's needs. (III)

57.22(2) Within 30 days of admission, the administrator or the administrator's designee shall, in conjunction with the resident, other facility staff or any organization that works with or serves the resident, develop a written, individualized, and integrated program of ongoing services for the resident. (III)

- a.* The program shall be planned and implemented to address the resident's priorities and assessed needs, such as living, rehabilitation, activity, behavioral, emotional, mental health and social, and shall

take into consideration the resident's personal goals and preferences, including the resident's preferred living situation. (III)

b. The service plan shall include specific goals and objectives with regular documentation of each. (III)

c. The service plan shall be reviewed at least quarterly, or more often as necessary. (III)

57.22(3) Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change, and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's family members or responsible party. (III)

481—57.23(135C) Resident activities program.

57.23(1) Each residential care facility shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

a. The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

b. The program shall include individual goals for each resident. (III)

c. The activity program shall include both group and individual activities. (III)

d. No resident shall be forced to participate in the activity program. (III)

57.23(2) *Coordination of activities program.*

a. Each residential care facility with over 15 beds shall employ a person to direct the activities program. (III)

b. ¹ ² Staffing for the activity program shall be provided on the minimum basis of 45 minutes per licensed bed per week. (II, III)

c. The activity coordinator shall have completed the activity coordinators' orientation course offered through the department within six months of employment or have comparable training and experience as approved by the department. (III)

d. The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

e. There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

57.23(3) *Duties of activity coordinator.* The activity coordinator shall:

a. Have access to all residents' records excluding financial records; (III)

b. Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)

c. Keep all necessary records including:

(1) Attendance; (III)

(2) Record individual resident progress notes at least every three months; (III)

(3) Monthly calendars, prepared in advance. (III)

d. Coordinate the activity program with all other services in the facility; (III)

e. Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

57.23(4) *Supplies, equipment, and storage.*

a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc. (III)

b. Storage shall be provided for recreational equipment and supplies. (III)

c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

¹ Emergency, pursuant to Iowa Code section 17A.5(2)"b"(2).

² Objection filed 2/14/79, see insert IAC 3/7/79.

481—57.24(135C) Resident advocate committee. Each facility shall have a resident advocate committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for resident advocate committees promulgated by the department on aging. (II)

57.24(1) Role of committee in complaint investigations.

a. The department shall notify the facility's resident advocate committee of a complaint from the public. The department shall not disclose the name of a complainant.

b. The department may refer complaints to the resident advocate committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department on aging. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation or the investigation.

c. When the department investigates a complaint, upon conclusion of its investigation, it shall notify the resident advocate committee and the department on aging of its findings, including any citations and fines issued.

d. Results of all complaint investigations addressed by the resident advocate committee shall be forwarded to the department within ten days of completion of the investigation.

57.24(2) The resident advocate committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

57.24(3) When requested, names, addresses and telephone numbers of family members shall be given to the resident advocate committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the family member's name, address or telephone number given to the resident advocate committee.

This rule is intended to implement Iowa Code section 135C.25.

481—57.25(135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

57.25(1) Fire safety.

a. All residential care facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

b. The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

57.25(2) Safety duties of administrator. The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)

a. The plan shall be posted. (III)

b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

57.25(3) Resident safety.

a. Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when under direct supervision. (II, III)

b. Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)

c. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

d. Smoking shall be permitted only in posted areas. (II, III)

e. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (II, III)

57.25(4) Restraints.

- a. Rescinded, effective 7/14/82.
- b. Residents shall not be kept behind locked doors;
- c. Temporary seclusion of residents shall be used only in an emergency to prevent injury to the resident or to others pending transfer to appropriate placement;
- d. A divided door equipped with a securing device that may be readily opened by personnel shall be considered an appropriate means of temporarily confining a resident in the resident's room;
- e. Divided doors shall be of such type that when the upper half is closed the lower section shall close.

481—57.26(135C) Housekeeping.

57.26(1) Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

57.26(2) Each resident unit shall be cleaned on a routine schedule. (III)

57.26(3) All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

57.26(4) A hallway or corridor shall not be used for storage of equipment. (III)

57.26(5) All odors shall be kept under control by cleanliness and proper ventilation. (III)

57.26(6) Clothing worn by personnel shall be clean and washable. (III)

57.26(7) Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

57.26(8) All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

57.26(9) Polishes used on floors shall provide a nonslip finish. (III)

57.26(10) Throw or scatter rugs shall not be permitted. (III)

57.26(11) Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

57.26(12) Residents shall not have access to storage areas for all cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials. (II, III)

57.26(13) Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

57.26(14) Personal possessions of residents which may constitute hazards to themselves or to others shall be removed and stored. (III)

481—57.27(135C) Maintenance.

57.27(1) Each facility shall establish a maintenance program to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and ensure sanitary practices throughout the facility. In facilities over 15 beds, this program shall be established in writing and available for review by the department. (III)

57.27(2) The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

57.27(3) Draperies and furniture shall be clean and in good repair. (III)

57.27(4) Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

57.27(5) The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the national electric code. (III)

57.27(6) All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

57.27(7) Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. (III)

57.27(8) The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

57.27(9) The facility shall be kept free of flies, other insects, and rodents. (III)

57.27(10) Janitor closet.

a. Facilities shall be provided with storage for cleaning equipment, supplies, and utensils. (III)

b. Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

c. In facilities licensed for over 15 beds, a janitor's closet shall be provided. It shall be equipped with water for filling scrub pails and a janitor's sink for emptying scrub pails. (III)

481—57.28(135C) Laundry.

57.28(1) All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

57.28(2) Except for related activities, the laundry room shall not be used for other purposes. (III)

57.28(3) Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

57.28(4) Residents' personal laundry shall be marked with an identification. (III)

57.28(5) Bed linens, towels, and washcloths shall be clean and stain-free. (III)

57.28(6) If laundry is done in the facility, the following shall be provided:

a. A clean, dry, well-lighted area to accommodate a washer and dryer of adequate size to serve the needs of the facility. (III)

b. In facilities of over 15 beds, the laundry room shall be divided into separate areas, one for sorting soiled linen and one for sorting and folding clean linen. (III)

481—57.29(135C) Garbage and waste disposal.

57.29(1) All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

57.29(2) All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

57.29(3) All containers shall be thoroughly cleaned each time the containers are emptied. (III)

57.29(4) All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

57.29(5) Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

481—57.30(135C) Buildings, furnishings, and equipment.

57.30(1) *Buildings—general requirements.*

a. For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than seven feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

b. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

c. All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

d. Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

e. Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

f. All fans located within seven feet of the floor shall be protected by screen guards of not more than one-fourth inch mesh. (III)

g. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

h. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

i. No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates except closets used for the storage of residents' clothing. (III)

j. All stairways in resident-occupied areas shall have substantial handrails on both sides. (III)

k. Each open stairway shall have protective barriers. (III)

l. Screens of 16 mesh per square inch shall be provided at all openings. (III)

m. Screen doors shall swing outward and be self-closing. At the discretion of the state fire marshal, screens for fire doors may swing in. (III)

n. All resident rooms shall have a door. (III)

o. All rooms in resident-occupied areas shall have general lighting switched at the entrance to each room. (III)

57.30(2) *Furnishings and equipment.*

a. All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a home-like atmosphere. (III)

c. Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

d. Night lights shall be provided in corridors, at stairways, attendant's stations and residents' bedrooms, and hazardous areas with no less than one foot-candle throughout the area at all times. (III)

57.30(3) *Dining and living rooms.*

a. Every facility shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 57.30(3) "e" are met. (III)

e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment.

f. Living rooms.

(1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)

(2) Living rooms shall be suitably furnished. (III)

(3) When space is provided to be used only for activities and recreational purposes, the area shall be at least 15 square feet per licensed bed. At least 50 percent of the required area must be in one room. (III)

g. Dining rooms.

(1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

(2) When space is provided to be used only for dining, the area shall total at least 15 square feet per licensed bed. (III)

57.30(4) *Bedrooms.*

a. Each resident shall be provided with a standard, single, or twin bed, substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. (III)

b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size. (III)

- c. Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)
- d. There shall be a comfortable chair, either a rocking chair or arm chair, per resident bed. The resident's personal wishes shall be considered. (III)
- e. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)
- f. Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)
- g. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)
- h. There shall be a wardrobe or closet in each resident's room. Minimum clear dimensions shall be 1' 10" deep by 1' 8" wide with full hanging space and provide a clothes rod and shelf. In a multiple bedroom, closet or wardrobe space shall be assigned each resident sufficient for the resident's needs. (III)
- i. Beds shall not be placed with the head of the bed in front of a window or radiator. (III)
- j. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)
- k. Reading lamps shall be provided each resident in the resident's room. (III)
- l. Each room shall have sufficient accessible mirrors to serve residents' needs. (III)
- m. Usable floor space of a room shall be no less than eight feet in any major dimension. (III)
- n. Bedrooms shall have a minimum of 80 square feet of usable floor space per bed. (III)
- o. There shall be no more than four residents per room. (III)
- p. Each resident room shall be provided with light and ventilation by means of a window or windows with an area equal to one-eighth of the total floor area. The windows shall be openable. (III)

57.30(5) Bath and toilet facilities.

- a. Provision shall be made for bars to hold individual towels and washcloths. (III)
- b. All lavatories shall have paper towel dispensers and an available supply of soap. (III)
- c. Minimum numbers of toilet and bath facilities shall be one lavatory, one toilet for each 10 residents, and one tub or shower for each 15 residents or fraction thereof. (III)
- d. There shall be a minimum of one bathroom with tub or shower, toilet stool and lavatory on each floor in multistory buildings for facilities licensed for over 15 beds. Separate toilets for the sexes shall be provided. (III)
- e. Grab bars shall be provided at all toilet stools, tubs, and showers. Grab bars, accessories, and anchorage shall have sufficient strength to sustain a deadweight of 250 pounds for five minutes. (III)
- f. Each toilet room shall have a door. (III)
- g. All toilet, bath, and shower facilities shall be supplied with adequate safety devices appropriate to the needs of the individual residents. Raised toilet seats shall be available for residents who are aged or infirm. (III)
- h. Toilet and bath facilities shall have an aggregate outside window area of at least four square feet. Facilities having a system of mechanical ventilation are exempt from this regulation. (III)
- i. Every facility shall provide a toilet and lavatory with grab bars for the public and staff. (III)

57.30(6) Heating. A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (III)

57.30(7) Water supply.

- a. Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)
- b. Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)
- c. A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)

- d. The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)
- e. Hot and cold running water under pressure shall be available in the facility. (III)
- f. Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department. (III)

57.30(8) Sewage system.

- a. Sewage shall be collected and disposed of in a manner approved by the department. Disposal into a municipal system will be considered as meeting this requirement. (III)
- b. Private sewage systems shall conform to the rules and regulations of the department of environmental quality, state health department, and the natural resources council. (III)
- c. Every facility shall have an interior plumbing system complete with flushing device. (III)

57.30(9) Attendant's station. In facilities over 15 beds, an attendant's station with a minimum of 40 square feet shall be provided which is centrally located in the resident area and shall have a well-lighted desk with the necessary equipment for the keeping of required records and supplies. (III)

481—57.31(135C) Family and employee accommodations.

57.31(1) Children under 14 years of age shall not be allowed into the service areas. (III)

57.31(2) The residents' bedrooms shall not be occupied by employees, family members of employees, or family members of the licensee. (III)

57.31(3) In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

57.31(4) In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

57.31(5) In all health care facilities, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

481—57.32(135C) Animals. No animals shall be allowed within the facility except with written approval of the department and under controlled conditions. (III)

481—57.33(135C) Environment and grounds.

57.33(1) A residential care facility shall be constructed in a neighborhood free from excessive noise, dirt, polluted, or odorous air, or similar disturbances. (III)

57.33(2) There shall be an area available for outdoor activities calculated at 25 square feet per licensed bed. Open air porches may be included in meeting such requirements. (III)

481—57.34(135C) Supplies.

57.34(1) Linen supplies.

a. There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

b. A complete change of bed linens shall be available in the linen storage area for each bed. (III)

c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom of odors. (III)

d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

e. Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

57.34(2) First aid kit. A first aid emergency kit shall be available on each floor in every facility. (II, III)

57.34(3) General supplies.

a. All equipment shall be properly cleaned and sanitized before use by another resident. (III)

b. Clean and sanitary storage shall be provided for equipment and supplies. (III)

481—57.35(135C) Residents' rights in general.

57.35(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 57.35(2) to 57.35(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

57.35(2) Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

a. Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)

b. As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

57.35(3) Policies and procedures regarding the use of chemical and physical restraints shall define the use of restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

57.35(4) Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

57.35(5) Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II)

57.35(6) Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies. (II)

a. The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

b. Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

c. A statement shall be signed by the resident, or the resident's responsible party, if applicable, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party. In the case of a mentally retarded resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

d. In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

e. All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English speaking, deaf or blind residents of changes. (II)

57.35(7) Each resident or responsible party shall be fully informed in a contract as required in rule 57.14(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges not covered by the facility's basic per diem rate. (II)

57.35(8) Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the

resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the department of health and human services protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or mentally retarded individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

a. The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either, shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

b. The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

c. If the physician determines or in the case of a confused or mentally retarded resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

d. Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended to December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

57.35(9) In residential care facilities which are also county care facilities, policies and procedures shall address the admission and retention of persons with histories of dangerous and disturbing behavior. For the purpose of this subrule, persons with histories of dangerous or disturbing behavior are those persons who have been committed for evaluation and found to be seriously mentally impaired pursuant to Iowa Code section 229.13 or 812.1 within six months of the request for admission to the facility. In addition to establishing the criteria for admission and retention of persons so defined, the policies and procedures shall provide for:

a. Reasonable precautions to prevent the resident from harming self, other residents, or employees of the facility.

b. Treatment of persons with mental illness as defined in Iowa Code section 229.1(1) which is provided in accordance with the individualized health care plan.

c. Ongoing and documented staff training on individualized health care planning for persons with mental illness.

481—57.36(135C) Involuntary discharge or transfer.

57.36(1) A facility shall not involuntarily discharge or transfer a resident from a facility except: for medical reasons; for the resident's welfare or that of other residents; for nonpayment for the resident's stay (as contained in the contract for the resident's stay), except as prohibited by Title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k and by reason of action pursuant to Iowa Code chapter 229. (I, II)

a. "Medical reasons" for transfer or discharge are based on the resident's needs and are determined and documented in the resident's record by the attending physician. Transfer or discharge may be required to provide a different level of care. (II)

b. "Welfare" of a resident or that of other residents refers to their social, emotional, or physical well-being. A resident might be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with other residents' needs and rights). Evidence that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other

residents shall be made by the administrator or designee and shall be in writing and shall include specific information to support this determination. (II)

c. Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. The 30-day requirement shall not apply in any of the following instances:

(1) If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) If the transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

d. The notice required by paragraph "*c*" shall contain all of the following information:

(1) The stated reason for the proposed transfer or discharge. (II)

(2) The effective date of the proposed transfer or discharge. (II)

(3) A statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals (hereinafter referred to as "department") within seven days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department of inspections and appeals designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." (II)

e. A request for a hearing made under 57.36(1) "*d*"(3) shall stay a transfer or discharge pending a hearing or appeal decision. (II)

f. The type of hearing shall be determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the licensee, resident, responsible party, and Iowa department on aging long-term care ombudsman of record, not later than five full business days after receipt of the request. This notice shall also inform the licensee, resident or responsible party that they have a right to appear at the hearing in person or be represented by their attorneys or other individual. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department on aging long-term care ombudsman shall have the right to appear at the hearing.

g. The hearing shall be heard by a department of inspections and appeals designee pursuant to Iowa Code chapter 17A. (The hearing shall be public unless the resident or representative requests in writing that it be closed.) The licensee or designee shall have the opportunity to present to the representative of the department any oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and responsible party shall also have an opportunity to present to the representative of the department any oral testimony or written material to show just cause why a transfer or discharge should not be made. In a determination as to whether a transfer or discharge is authorized, the burden of proof rests on the party requesting the transfer or discharge.

h. Based upon all testimony and material submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by certified mail to the licensee, resident, responsible party, and department on aging long-term

care ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision.

i. A copy of the notice required by paragraph “c” shall be personally delivered to the resident and a copy placed in the resident’s record. A copy shall also be transmitted to the department, the resident’s responsible party, physician, the person or agency responsible for the resident’s placement, maintenance, and care in the facility, and the department on aging long-term care ombudsman.

j. If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

k. The involuntary transfer or discharge shall be discussed with the resident, the resident’s responsible party, and the person or agency responsible for the resident’s placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator’s designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident’s record. (II)

l. The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident’s record. (II)

(1) Counseling shall be provided by a qualified individual who meets one of the following criteria:

1. Has a bachelor’s or master’s degree in social work from an accredited college. (II)

2. Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with a public or private agency. (II)

3. Has been employed in a social work capacity for a minimum of four years in a public or private agency. (II)

4. Is a licensed psychologist or psychiatrist. (II)

5. Is any other person of the resident’s choice. (II)

(2) The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be discharged or transferred. (II)

(3) The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

m. In the case of an emergency transfer or discharge as outlined in 57.36(1)“c”(1), the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident’s file and it must contain all the information required by subparagraphs (1) and (2) of 57.36(1)“d.” In addition, the notice must contain a statement in not less than 12-point type (elite), which reads: “You have a right to appeal the facility’s decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals within 7 days after receiving this notice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.”

A hearing requested pursuant to this subrule shall be held in accordance with paragraphs “f,” “g,” and “h.” (II)

n. Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility’s license by the department of inspections and appeals. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

57.36(2) Intrafacility transfer:

a. Residents shall not be relocated from room to room within a licensed health care facility arbitrarily. (I, II) Involuntary relocation may occur only in the following situations, and the situation shall be documented in the resident’s record.

(1) Incompatibility with or disturbing to other roommates, as documented in the resident’s record.
 (2) For the welfare of the resident or other residents of the facility.
 (3) For medical, nursing or psychosocial reasons, as documented in the resident’s record, as judged by the attending physician, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.

(4) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex.

(5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

b. Unreasonable and unjustified reasons for changing a resident’s room without the concurrence of the resident or responsible party include:

- (1) Change from private pay status to Title XIX, except as outlined in 57.36(2)“a”(5). (II)
- (2) As punishment or behavior modification (except as specified in 57.36(2)“a”(1)). (II)
- (3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph “a,” the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. The notification shall be documented in the resident’s record and signed by the resident or responsible party. (II)

d. If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately, or as soon as possible, of the condition requiring emergency relocation and the notification shall be documented. (II)

481—57.37(135C) Residents’ rights. Each resident shall be encouraged and assisted throughout the resident’s period of stay, to exercise the resident’s rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident’s choice, free from interference, coercion, discrimination, or reprisal. (II)

57.37(1) The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

57.37(2) The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

- a.* Designation of an employee responsible for handling grievances and recommendations. (II)
- b.* A method of investigating and assessing the validity of a grievance or recommendation. (II)
- c.* Methods of resolving grievances. (II)
- d.* Methods of recording grievances and actions taken. (II)

57.37(3) The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, and resident advocate committee members and the text of Iowa Code section 135C.46 to provide to residents a further course of redress. (II)

481—57.38(135C) Financial affairs—management. Each resident, who has not been assigned a guardian or conservator by the court, may manage the resident's own personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

57.38(1) The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

57.38(2) An employee shall be designated in writing to be responsible for resident accounts. (II)

57.38(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code subsection 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or mentally retarded resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

57.38(4) If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge having seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

57.38(5) A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

57.38(6) A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

481—57.39(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse. Each resident shall be free from chemical and physical restraints, except in an emergency for the shortest amount of time necessary to protect the resident from injury to the resident or to others, pending the immediate transfer to an appropriate facility. The decision to use restraints on an emergency basis shall be made by the designated charge person who shall promptly report the action taken to the physician and the reasons for using restraints shall be documented in the resident's record. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

57.39(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

57.39(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

57.39(3) Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff. (II)

57.39(4) Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain that separation until the abuse investigation is completed. (I, II)

57.39(5) Suspected abuse reports. The department shall investigate all complaints of dependent adult abuse which are alleged to have happened in a health care facility. The department shall inform the department of human services of the results of all evaluations and dispositions of dependent adult abuse investigations.

57.39(6) Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

481—57.40(135C) Resident records. Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

57.40(1) The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

57.40(2) Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

57.40(3) The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

481—57.41(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (II)

57.41(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

57.41(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

57.41(3) Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

57.41(4) Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

57.41(5) Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply under emergency conditions. (II)

481—57.42(135C) Resident work. No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. (II)

57.42(1) Residents may not be used to provide a source of labor for the facility against their will. Physician's approval is required for all work programs. (I, II)

57.42(2) Residents who perform work for the facility must receive remuneration unless the work is part of their approved training program. Persons on the resident census performing work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

481—57.43(135C) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

57.43(1) Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

57.43(2) Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

a. The resident refuses to see the visitor(s). (II)

b. The resident's physician documents specific reasons why such a visit would be harmful to the resident's health. (II)

c. The visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

57.43(3) Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician; at least quarterly by the facility's staff; or at the resident's request. (II)

57.43(4) Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

57.43(5) Telephones consistent with ANSI standards (405.1134(c)) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

57.43(6) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

57.43(7) Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified mental retardation professional, or facility administrator for refusing permission. (II)

57.43(8) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

481—57.44(135C) Resident activities. Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the attending physician or qualified mental retardation professional as appropriate in the resident's resident record. (II)

57.44(1) Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

57.44(2) All residents shall have the freedom to refuse to participate in these activities. (II)

481—57.45(135C) Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

57.45(1) Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

57.45(2) Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

57.45(3) Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart. The facility shall be responsible for secure storage of the items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

57.45(4) A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

57.45(5) A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

481—57.46(135C) Family visits. Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room, if available. (II)

57.46(1) The facility shall provide for needed privacy in visits between spouses. (II)

57.46(2) Spouses who are residents in the same facility shall be permitted to share a room, if available, unless one of their attending physicians documents in the medical record those specific reasons why such an arrangement would have an adverse effect on the health of the resident. (II)

57.46(3) Family members shall be permitted to share a room, if available, if requested by both parties, unless one of their attending physicians documents in the medical record those specific reasons why such an agreement would have an adverse effect on the health of the resident. (II)

481—57.47(135C) Choice of physician. Each resident shall be permitted free choice of a physician and a pharmacy, if accessible. The facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility. (II)

481—57.48(135C) Incompetent residents.

57.48(1) Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

57.48(2) The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

481—57.49(135C) County care facilities. In addition to Chapter 57 licensing rules, county care facilities licensed as residential care facilities must also comply with department of human services rules, 441—Chapter 37. Violations of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

481—57.50(135C) Another business or activity in a facility. A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs "a" through "j" of this rule. (I, II, III)

57.50(1) The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a. Health and safety risks for residents;
- b. Compatibility of the proposed business or activity with the facility program;
- c. Noise created by the proposed business or activity;
- d. Odors created by the proposed business or activity;
- e. Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;

- f.* Use of the facility's corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- g.* Proposed staffing for the business or activity;
- h.* Sharing of services and staff between the proposed business or activity and the facility;
- i.* Facility layout and design; and
- j.* Parking area utilized by the business or activity.

57.50(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

57.50(3) A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 60. (I, II, III)

481—57.51(135C) Respite care services. Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A residential care facility which chooses to provide respite care services must meet the following requirements related to respite services and must be licensed as a residential care facility.

57.51(1) A residential care facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

57.51(2) Rule 481—57.36(135C), regarding involuntary discharge or transfer rights, does not apply to residents who are being cared for under a respite care contract.

57.51(3) Pursuant to rule 481—57.14(135C), the facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements under 481—57.14(135C), except the requirements under subrule 57.14(7).

57.51(4) Respite care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.6(1), 135C.14, 135C.23(2), 135C.25, 135C.36, 227.4, 235B.1(6), and 235B.1(11).

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⁰ Two or more ARCs

¹ Effective date of 470—57.15(2) “a” and “b” delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAB 6/4/86.

² See IAB, Inspections and Appeals Department.

³ Effective date of 481—57.12(2) “a,” last paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held July 8, 1993.

OBJECTION

At its February 13 meeting the Administrative Rules Review Committee voted the following objection: [Subrules 57.23(2)“b,” 58.26(2)“b,” 59.31(2)“b,” 63.21(3)“b,” published IAB 12/13/78]

The committee objects to the amendments to 470* IAC 57.23(2)“b,” 58.26(2)“b,” 59.31(2)“b” and 63.21(3)“b,” which strike the phrase “Twenty-five percent of the staffing may be provided by qualified volunteers. The time shall be spent in working with the organized program activity.”, on the grounds these provisions are unreasonable. It is the understanding of the committee these deletions in effect require facilities to employ a person to coordinate recreation activities. It is the feeling of the committee this would result in higher per bed costs without demonstrably improving the services rendered to the patient. Volunteers have always played a major role in health care institutions, and no evidence has been submitted indicating a decline in that role or in public interest in donating time and energy.

These amendments appear in the 12-13-78 IAB, and have been filed under the emergency provisions of chapter 17A, 1979 Code.

*Chapter 57 transferred to Inspections and Appeals[481], IAC 7/15/87.

CHAPTER 58
NURSING FACILITIES

[Prior to 7/15/87, Health Department[470] Ch 58]

481—58.1(135C) Definitions. For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words “shall” and “must” indicates those standards are mandatory. The use of the words “should” and “could” indicates those standards are recommended.

“*Accommodation*” means the provision of lodging, including sleeping, dining, and living areas.

“*Administrator*” means a person licensed pursuant to Iowa Code chapter 147 who administers, manages, supervises, and is in general administrative charge of a nursing facility, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

“*Alcoholic*” means a person in a state of dependency resulting from excessive or prolonged consumption of alcoholic beverages as defined in Iowa Code section 125.2.

“*Ambulatory*” means the condition of a person who immediately and without aid of another is physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“*Basement*” means that part of a building where the finish floor is more than 30 inches below the finish grade.

“*Board*” means the regular provision of meals.

“*Chairfast*” means capable of maintaining a sitting position but lacking the capacity of bearing own weight, even with the aid of a mechanical device or another individual.

“*Communicable disease*” means a disease caused by the presence of viruses or microbial agents within a person’s body, which agents may be transmitted either directly or indirectly to other persons.

“*Department*” means the state department of inspections and appeals.

“*Distinct part*” means a clearly identifiable area or section within a health care facility, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

“*Drug addiction*” means a state of dependency, as medically determined, resulting from excessive or prolonged use of drugs as defined in Iowa Code chapter 124.

“*Medication*” means any drug including over-the-counter substances ordered and administered under the direction of the physician.

“*Nonambulatory*” means the condition of a person who immediately and without aid of another is not physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“*Nourishing snack*” is defined as a verbal offering of items, single or in combination, from the basic food groups. Adequacy of the “nourishing snack” will be determined both by resident interviews and by evaluation of the overall nutritional status of residents in the facility.

“*Person directed care environment*” means the provision of care and services provided in a facility that promotes decision making and choices by the resident, enhances the primary caregiver’s capacity to respond to each resident’s needs, and promotes a homelike environment. Examples of a person directed care environment include, but are not limited to, the Green House concept, the Eden alternative, service houses and neighborhoods.

“*Personal care*” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are assistance in getting in and out of bed, assistance with personal hygiene and bathing, assistance with dressing, meal assistance, and supervision over medications which can be self-administered.

“*Potentially hazardous food*” means a food that is natural or synthetic and that requires temperature control because it is in a form capable of supporting the rapid and progressive growth of infectious or toxigenic microorganisms, the growth and toxin production of clostridium botulinum, or in raw shell eggs, the growth of salmonella enteritidis. Potentially hazardous food includes an animal food (a food of animal origin) that is raw or heat-treated; a food of plant origin that is heat-treated or consists of raw

seed sprouts; cut melons; and garlic and oil mixtures that are not acidified or otherwise modified at a food processing plant in a way that results in mixtures that do not support growth of bacteria.

“Program of care” means all services being provided for a resident in a health care facility.

“Qualified mental retardation professional” means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and having one year’s experience working with the mentally retarded.

“Qualified nurse” means a registered nurse or a licensed practical nurse, as defined in Iowa Code chapter 152.

“Rate” means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these rules and regulations.

“Responsible party” means the person who signs or cosigns the admission agreement required in 481—58.13(135C) or the resident’s guardian or conservator if one has been appointed. In the event that a resident does not have a guardian, conservator or other person signing the admission agreement, the term “responsible party” shall include the resident’s sponsoring agency, e.g., the department of human services, the U.S. Department of Veterans Affairs, religious groups, fraternal organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

“Restraints” means any chemical, manual method or physical or mechanical device, material, or equipment attached to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.

“Substantial evening meal” is defined as an offering of three or more menu items at one time, one of which includes a high protein such as meat, fish, eggs or cheese. The meal would represent no less than 20 percent of the day’s total nutritional requirements.

481—58.2(135C) Variances. Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual nursing facility. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

58.2(1) To request a variance, the licensee must:

- a. Apply for variance in writing on a form provided by the department;
- b. Cite the rule or rules from which a variance is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain alternate arrangements or compensating circumstances which justify the variance;
- e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

58.2(2) Upon receipt of a request for variance, the director of inspections and appeals will:

- a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;
- b. If the request meets the above criteria, evaluate the alternate arrangements or compensating circumstances against the requirement of the rules;
- c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;
- d. Consult with the applicant if additional information is required.

58.2(3) Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

481—58.3(135C) Application for licensure.

58.3(1) Initial application and licensing. In order to obtain an initial nursing facility license, for a nursing facility which is currently licensed, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Applicable exceptions found in rule 481—61.2(135C) shall apply based on the construction date of the facility.

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the nursing facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door location;

e. Submit a photograph of the front and side elevation of the nursing facility;

f. Submit the statutory fee for a nursing facility license;

g. Meet the requirements of a nursing facility for which licensure application is made;

h. Comply with all other local statutes and ordinances in existence at the time of licensure;

i. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

58.3(2) In order to obtain an initial nursing facility license for a facility not currently licensed as a nursing facility, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Exceptions noted in 481—subrule 61.1(2) shall not apply;

b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the nursing facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door locations;

e. Submit a photograph of the front and side elevation of the nursing facility;

f. Submit the statutory fee for a nursing facility license;

g. Comply with all other local statutes and ordinances in existence at the time of licensure;

h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

58.3(3) *Renewal application.* In order to obtain a renewal of the nursing facility license, the applicant must:

a. Submit the completed application form 30 days prior to annual license renewal date of nursing facility license;

b. Submit the statutory license fee for a nursing facility with the application for renewal;

c. Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;

d. Submit appropriate changes in the résumé to reflect any changes in the resident care program or other services.

58.3(4) Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

481—58.4(135C) General requirements.

58.4(1) The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

58.4(2) The license shall be valid only in the possession of the licensee to whom it is issued.

58.4(3) The posted license shall accurately reflect the current status of the nursing facility. (III)

58.4(4) Licenses expire one year after the date of issuance or as indicated on the license.

58.4(5) No nursing facility shall be licensed for more beds than have been approved by the health facilities construction review committee.

58.4(6) Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

481—58.5(135C) Notifications required by the department. The department shall be notified:

58.5(1) Within 48 hours, by letter, of any reduction or loss of nursing or dietary staff lasting more than seven days which places the staffing ratio below that required for licensing. No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

58.5(2) Of any proposed change in the nursing facility's functional operation or addition or deletion of required services; (III)

58.5(3) Thirty days before addition, alteration, or new construction is begun in the nursing facility or on the premises; (III)

58.5(4) Thirty days in advance of closure of the nursing facility; (III)

58.5(5) Within two weeks of any change in administrator; (III)

58.5(6) When any change in the category of license is sought; (III)

58.5(7) Prior to the purchase, transfer, assignment, or lease of a nursing facility, the licensee shall:

- a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)
- b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)
- c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's nursing facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

58.5(8) Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a nursing facility, the department shall upon request send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

481—58.6(135C) Witness fees. Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

481—58.7(135C) Licenses for distinct parts.

58.7(1) Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

58.7(2) The following requirements shall be met for a separate licensing of a distinct part:

a. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)

b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

c. A distinct part must be operationally and financially feasible;

d. A separate staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)

e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry, and dietary in common with each other.

481—58.8(135C) Administrator.

58.8(1) Each nursing facility shall have one person in charge, duly licensed as a nursing home administrator or acting in a provisional capacity. (III)

58.8(2) A licensed administrator may act as an administrator for not more than two nursing facilities.

- a. The distance between the two facilities shall be no greater than 50 miles. (II)
- b. The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)
- c. The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

58.8(3) The licensee may be the licensed nursing home administrator providing the licensee meets the requirements as set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

58.8(4) A provisional administrator may be appointed on a temporary basis by the nursing facility licensee to assume the administrative duties when the facility, through no fault of its own, has lost its administrator and has been unable to replace the administrator provided that no facility licensed under Iowa Code chapter 135C shall be permitted to have a provisional administrator for more than 6 months in any 12-month period and further provided that:

- a. The department has been notified prior to the date of the administrator's appointment; (III)
- b. The board of examiners for nursing home administrators has approved the administrator's appointment and has confirmed such appointment in writing to the department. (III)

58.8(5) In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

- a. Be knowledgeable of the operation of the facility; (III)
- b. Have access to records concerned with the operation of the facility; (III)
- c. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)
- d. Be at least 18 years of age; (III)
- e. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)
- f. Have had training to carry out assignments and take care of emergencies and sudden illness of residents. (III)

58.8(6) A licensed administrator in charge of two facilities shall employ an individual designated as a full-time assistant administrator for each facility. (III)

58.8(7) An administrator of only one facility shall be considered as a full-time employee. Full-time employment is defined as 40 hours per week. (III)

481—58.9(135C) Administration.

58.9(1) The licensee shall:

- a. Assume the responsibility for the overall operation of the nursing facility; (III)
- b. Be responsible for compliance with all applicable laws and with the rules of the department; (III)
- c. Establish written policies, which shall be available for review, for the operation of the nursing facility. (III)

58.9(2) The administrator shall:

- a. Be responsible for the selection and direction of competent personnel to provide services for the resident care program; (III)
- b. Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)
- c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)
- d. Make available the nursing facility payroll records for departmental review as needed; (III)
- e. Be required to maintain a staffing pattern of all departments. These records must be maintained for six months and are to be made available for departmental review. (III)

481—58.10(135C) General policies.

58.10(1) There shall be written personnel policies in facilities of more than 15 beds to include hours of work, and attendance at educational programs. (III)

58.10(2) There shall be a written job description developed for each category of worker. The job description shall include title of job, job summary, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

- a. Employees shall have a physical examination before employment. (I, II, III)
- b. Employees shall have a physical examination at least every four years. (I, II, III)
- c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

58.10(4) Health certificates for all employees shall be available for review. (III)

58.10(5) Rescinded IAB 10/19/88, effective 11/23/88.

58.10(6) There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident which includes the individual to be contacted in case of emergency. (III)

58.10(7) The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

58.10(8) Infection control program. Each facility shall have a written and implemented infection control and exposure control program with policies and procedures based on the guidelines issued by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. (I, II, III) CDC guidelines are available at <http://www.cdc.gov/ncidod/dhqp/index.html>.

58.10(9) Infection control committee. Each facility shall establish an infection control committee of representative professional staff responsible for overall infection control in the facility. (III)

a. The committee shall annually review and revise the infection control policies and procedures to monitor effectiveness and suggest improvement. (III)

b. The committee shall meet at least quarterly, submit reports to the administrator, and maintain minutes in sufficient detail to document its proceedings and actions. (III)

c. The committee shall monitor the health aspect and the environment of the facility. (III)

58.10(10) There shall be written policies for resident care programs and services as outlined in these rules. (III)

58.10(11) Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

[ARC 0663C, IAB 4/3/13, effective 5/8/13]

481—58.11(135C) Personnel.

58.11(1) *General qualifications.*

a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a nursing facility. (II)

b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a nursing facility. (II)

c. No person shall be allowed to provide services in a facility if the person has a disease:

- (1) Which is transmissible through required workplace contact, (I, II, III)
- (2) Which presents a significant risk of infecting others, (I, II, III)
- (3) Which presents a substantial possibility of harming others, and (I, II, III)
- (4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

d. Reserved.

e. Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

f. Persons employed in all departments, except the nursing department of a nursing facility shall be qualified through formal training or through prior experience to perform the type of work for which they have been employed. Prior experience means at least 240 hours of full-time employment in a field related to their duties. Persons may be hired in laundry, housekeeping, activities and dietary without experience or training if the facility institutes a formal in-service training program to fit the job description in question and documents such as having taken place within 30 days after the initial hiring of such untrained employees. (III)

g. Rescinded, effective 7/14/82.

h. The health services supervisor shall be a qualified nurse as defined in these regulations. (II)

i. Those persons employed as nurse's aides, orderlies, or attendants in a nursing facility who have not completed the state-approved 75-hour nurse's aide program shall be required to participate in a structured on-the-job training program of 20 hours' duration to be conducted prior to any resident contact, except that contact required by the training program. This educational program shall be in addition to facility orientation. Each individual shall demonstrate competencies covered by the curriculum. This shall be observed and documented by an R.N. and maintained in the personnel file. No aide shall work independently until this is accomplished, nor shall the aide's hours count toward meeting the minimum hours of nursing care required by the department. The curriculum shall be approved by the department. An aide who has completed the state-approved 75-hour course may model skills to be learned.

Further, such personnel shall be enrolled in a state-approved 75-hour nurse's aide program to be completed no later than six months from the date of employment. If the state-approved 75-hour program has been completed prior to employment, the on-the-job training program requirement is waived. The 20-hour course is in addition to the 75-hour course and is not a substitute in whole or in part. The 75-hour program, approved by the department, may be provided by the facility or academic institution.

Newly hired aides who have completed the state-approved 75-hour course shall demonstrate competencies taught in the 20-hour course upon hire. This shall be observed and documented by an R.N. and maintained in the personnel file.

All personnel administering medications must have completed the state-approved training program in medication administration. (II)

j. There shall be an organized ongoing in-service educational and training program planned in advance for all personnel in all departments. (II, III)

k. Nurse aides, orderlies or attendants in a nursing facility who have received training other than the Iowa state-approved program, must pass a challenge examination approved by the department of inspections and appeals. Evidence of prior formal training in a nursing aide, orderly, attendant, or other comparable program must be presented to the facility or institution conducting the challenge examination before the examination is given. The approved facility or institution, following department of inspections and appeals guidelines, shall make the determination of who is qualified to take the examination. Documentation of the challenge examinations administered shall be maintained.

58.11(2) Nursing supervision and staffing.

a. Rescinded IAB 8/7/91, effective 7/19/91.

b. Where only part-time nurses are employed, one nurse shall be designated health service supervisor. (III)

c. A qualified nurse shall be employed to relieve the supervising nurses, including charge nurses, on holidays, vacation, sick leave, days off, absences or emergencies. Pertinent information for contacting such relief person shall be posted at the nurse's station. (III)

d. When the health service supervisor serves as the administrator of a facility 50 beds and over, a qualified nurse must be employed to relieve the health service supervisor of nursing responsibilities. (III)

e. The department may establish on an individual facility basis the numbers and qualifications of the staff required in the facility using as its criteria the services being offered and the needs of the residents. (III)

f. Additional staffing, above the minimum ratio, may be required by the department commensurate with the needs of the individual residents. (III)

g. The minimum hours of resident care personnel required for residents needing intermediate nursing care shall be 2.0 hours per resident day computed on a seven-day week. A minimum of 20 percent of this time shall be provided by qualified nurses. If the maximum medical assistance rate is reduced below the 74th percentile, the requirement will return to 1.7 hours per resident per day computed on a seven-day week. A minimum of 20 percent of this time shall be provided by qualified nurses. (II, III)

h. The health service supervisor's hours worked per week shall be included in computing the 20 percent requirement.

i. A nursing facility of 75 beds or more shall have a qualified nurse on duty 24 hours per day, seven days a week. (II, III)

j. In facilities under 75 beds, if the health service supervisor is a licensed practical nurse, the facility shall employ a registered nurse, for at least four hours each week for consultation, who must be on duty at the same time as the health service supervisor. (II, III)

(1) This shall be an on-site consultation and documentation shall be made of the visit. (III)

(2) The registered nurse-consultant shall have responsibilities clearly outlined in a written agreement with the facility. (III)

(3) Consultation shall include but not be limited to the following: counseling the health service supervisor in the management of the health services; (III) reviewing and evaluating the health services in determining that the needs of the residents are met; (II, III) conducting a review of medications at least monthly if the facility does not employ a registered nurse part-time. (II, III)

k. Facilities with 75 or more beds must employ a health service supervisor who is a registered nurse. (II)

l. There shall be at least two people who shall be capable of rendering nursing service, awake, dressed, and on duty at all times. (II)

m. Physician's orders shall be implemented by qualified personnel. (II, III)

58.11(3) Personnel histories.

a. Each health care facility shall submit a form specified by the department of public safety to the department of public safety, and receive the results of a criminal history check and dependent adult abuse record check before any person is employed in a health care facility. The health care facility shall submit a form specified by the department of human services to the department of human services to request a child abuse history check. For the purposes of this subrule, "employed in a facility" shall be defined as any individual who is paid, either by the health care facility or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors), to provide direct or indirect treatment or services to residents in a health care facility. 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 requirements of this subrule are individuals such as building contractors, repair workers or others who are in a facility for a very limited purpose, are not in the facility on a regular basis, and do not provide any treatment or services to the residents of the health care facility. (I, II, III)

b. A person who has a criminal record or founded dependent adult abuse report cannot be employed in a health care facility unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse report does not merit prohibition from employment. (I, II, III)

c. Each health care facility shall ask each person seeking employment in a facility "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of crime in this state or any other state?" The person shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The person shall indicate, by signature, that the person has been informed that the record checks will be conducted. (I, II, III)

d. If a person has a record of founded child abuse in Iowa or any other state, the person shall not be employed in a health care facility unless the department of human services has evaluated the crime or founded report and concluded that the report does not merit prohibition of employment. (I, II, III)

e. Proof of dependent adult abuse and criminal history checks may be kept in files maintained by the temporary employee agencies and contractors. Facilities may require temporary agencies and contractors to provide a copy of the results of the dependent adult abuse and criminal history checks. (I, II, III)

481—58.12(135C) Admission, transfer, and discharge.

58.12(1) General admission policies.

a. No resident shall be admitted or retained in a nursing facility who is in need of greater services than the facility can provide. (II, III)

b. No nursing facility shall admit more residents than the number of beds for which it is licensed, except guest rooms for visitors. (II, III)

c. There shall be no more beds erected than is stipulated on the license. (II, III)

d. There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

e. The admission of a resident to a nursing facility shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal representative. (III)

f. The admission of a resident shall not grant the nursing facility the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and safe and orderly management of the facility as required by these rules. (III)

g. A nursing facility shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

h. Rescinded, effective 7/14/82.

i. Funds or properties received by the nursing facility belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

j. Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

k. No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity.

l. Within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A, the facility shall ask the resident or the resident's personal representative whether the resident is a veteran and shall document the response. If the facility determines that the resident is a potential veteran, the facility shall report the resident's name along with the names of the resident's spouse and any dependent children, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services.

If a resident is eligible for benefits through the United States Department of Veterans Affairs or other third-party payor, the facility first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II, III)

58.12(2) Discharge or transfer.

a. Prior notification shall be made to the resident, as well as the resident's next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

b. Proper arrangements shall be made by the nursing facility for the welfare of the resident prior to transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

c. The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such a discharge or transfer. (II, III)

d. Advance notification will be made to the receiving facility prior to the transfer of any resident. (III)

e. When a resident is transferred or discharged, the appropriate record as set forth in 58.15(2) "k" of these rules will accompany the resident. (II, III)

f. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

481—58.13(135C) Contracts. Each contract shall:

58.13(1) State the base rate or scale per day or per month, the services included, and the method of payment; (III)

58.13(2) Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. Furthermore, the contract shall: (III)

a. Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in 58.13(3); (III)

b. State the method of payment of additional charges; (III)

c. Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

d. State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.; (III)

58.13(3) Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the nursing assessment at the time of admission, which is determined in consultation with the administrator; (III)

58.13(4) Include the total fee to be charged initially to the specific resident; (III)

58.13(5) State the conditions whereby the facility may make adjustments to the facility's overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

a. Written notification to the resident, or responsible party when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to effective date of such changes; (III)

b. Notification to the resident, or responsible party when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)

58.13(6) State the terms of agreement in regard to refund of all advance payments in the event of transfer, death, voluntary or involuntary discharge; (III)

58.13(7) State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party.

a. The facility shall ask the resident or responsible party if the resident wants the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

b. The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

58.13(8) State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

58.13(9) State the conditions of voluntary discharge or transfer; (III)

58.13(10) Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter; (III)

58.13(11) Each party shall receive a copy of the signed contract. (III)

481—58.14(135C) Medical services.

58.14(1) Each resident in a nursing facility shall designate a licensed physician who may be called when needed. Professional management of a resident's care shall be the responsibility of the hospice program when:

a. The resident is terminally ill, and

b. The resident has elected to receive hospice services under the federal Medicare program from a Medicare-certified hospice program, and

c. The facility and the hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of hospice care.

58.14(2) Each resident admitted to a nursing facility shall have had a physical examination prior to admission. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be made part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (III)

58.14(3) Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

58.14(4) Rescinded, effective 7/14/82.

58.14(5) The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

58.14(6) A schedule listing the names and telephone numbers of the physicians shall be posted in each nursing station. (III)

58.14(7) Residents shall be admitted to a nursing facility only on a written order signed by a physician certifying that the individual being admitted requires no greater degree of nursing care than the facility is licensed to provide. (III)

58.14(8) Each resident shall be visited by or shall visit the resident's physician at least twice a year. The year period shall be measured from the date of admission and is not to include preadmission physicals. Notwithstanding the provisions of 42 CFR 483.40, any required physician task or visit in a nursing facility may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with a physician, as outlined in Table 1. (III)

In dually certified skilled nursing/nursing facilities, the advanced registered nurse practitioner, clinical nurse specialist, and physician assistant must follow the skilled nursing facility requirements for services for skilled nursing facility stays. For nursing facility stays in skilled nursing/nursing facilities, any required physician task or visit may be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant working in collaboration with the physician.

Nurse practitioners, clinical nurse specialists, and physician assistants may perform other tasks that are not reserved to the physician such as visits outside the normal schedule needed to address new symptoms or other changes in medical status.

Table 1: Authority for non-physician practitioners to perform visits, sign orders, and sign certifications/recertifications when permitted by state law*

	Initial Comprehensive Visit/Orders	Other Required Visits ¹	Other Medically Necessary Visits and Orders ²	Certification/Recertification
Skilled Nursing Facilities				
Nurse practitioner and clinical nurse specialist employed by the facility	May not perform/May not sign	May perform	May perform and sign	May not sign
Nurse practitioner and clinical nurse specialist not a facility employee	May not perform/May not sign	May perform	May perform and sign	May sign subject to state requirements
Physician assistant regardless of employer	May not perform/May not sign	May perform	May perform and sign	May not sign
Nursing Facilities				
Nurse practitioner, clinical nurse specialist, and physician assistant employed by the facility	May not perform/May not sign	May not perform	May perform and sign	May sign subject to state requirements
Nurse practitioner, clinical nurse specialist, and physician assistant not a facility employee	May perform/May sign	May perform	May perform and sign	May sign subject to state requirements

*As permitted by state law governing the scope and practice of nurse practitioners, clinical nurse specialists, and physician assistants.

¹ Other required visits include the skilled nursing resident monthly visits that may be alternated between physician and advanced registered nurse practitioners, clinical nurse specialists, or physician assistants after the initial comprehensive visit is completed.

² Medically necessary visits may be performed prior to the initial comprehensive visit.

481—58.15(135C) Records.

58.15(1) Resident admission record. The licensee shall keep a permanent record on all residents admitted to a nursing facility with all entries current, dated, and signed. This shall be a part of the resident clinical record. (III) The admission record form shall include:

- a. Name and previous address of resident; (III)
- b. Birth date, sex, and marital status of resident; (III)
- c. Church affiliation; (III)
- d. Physician's name, telephone number, and address; (III)
- e. Dentist's name, telephone number, and address; (III)
- f. Name, address, and telephone number of next of kin or legal representative; (III)
- g. Name, address, and telephone number of person to be notified in case of emergency; (III)
- h. Mortician's name, telephone number, and address; (III)
- i. Pharmacist's name, telephone number, and address. (III)

58.15(2) Resident clinical record. There shall be a separate clinical record for each resident admitted to a nursing facility with all entries current, dated, and signed. (III) The resident clinical record shall include:

- a. Admission record; (III)
- b. Admission diagnosis; (III)
- c. Physical examination: The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, tuberculosis status, physical examination, diagnosis, statement of chief complaints,

estimation of restoration potential and results of any diagnostic procedures. The report of the physical examination shall be signed by the physician. (III)

d. Physician's certification that the resident requires no greater degree of nursing care than the facility is licensed to provide; (III)

e. Physician's orders for medication, treatment, and diet in writing and signed by the physician quarterly; (III)

f. Progress notes.

(1) Physician shall enter a progress note at the time of each visit; (III)

(2) Other professionals, i.e., dentists, social workers, physical therapists, pharmacists, and others shall enter a progress note at the time of each visit; (III)

g. All laboratory, X-ray, and other diagnostic reports; (III)

h. Nurse's record including:

(1) Admitting notes including time and mode of transportation; room assignment; disposition of valuables; symptoms and complaints; general condition; vital signs; and weight; (II, III)

(2) Routine notes including physician's visits; telephone calls to and from the physician; unusual incidents and accidents; change of condition; social interaction; and P.R.N. medications administered including time and reason administered, and resident's reaction; (II, III)

(3) Discharge or transfer notes including time and mode of transportation; resident's general condition; instructions given to resident or legal representative; list of medications and disposition; and completion of transfer form for continuity of care; (II, III)

(4) Death notes including notification of physician and family to include time, disposition of body, resident's personal possessions and medications; and complete and accurate notes of resident's vital signs and symptoms preceding death; (III)

i. Medication record.

(1) An accurate record of all medications administered shall be maintained for each resident. (II, III)

(2) Schedule II drug records shall be kept in accordance with state and federal laws; (II, III)

j. Death record. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)

k. Transfer form.

(1) The transfer form shall include identification data from the admission record, name of transferring institution, name of receiving institution, and date of transfer; (III)

(2) The nurse's report shall include resident attitudes, behavior, interests, functional abilities (activities of daily living), unusual treatments, nursing care, problems, likes and dislikes, nutrition, current medications (when last given), and condition on transfer; (III)

(3) The physician's report shall include reason for transfer, medications, treatment, diet, activities, significant laboratory and X-ray findings, and diagnosis and prognosis; (III)

l. Consultation reports shall indicate services rendered by allied health professionals in the facility or in health-centered agencies such as dentists, physical therapists, podiatrists, oculists, and others. (III)

58.15(3) Resident personal record. Personal records may be kept as a separate file by the facility.

a. Personal records may include factual information regarding personal statistics, family and responsible relative resources, financial status, and other confidential information.

b. Personal records shall be accessible to professional staff involved in planning for services to meet the needs of the resident. (III)

c. When the resident's records are closed, the information shall become a part of the final record. (III)

d. Personal records shall include a duplicate copy of the contract(s). (III)

58.15(4) Incident record.

a. Each nursing facility shall maintain an incident record report and shall have available incident report forms. (III)

- b. Report of incidents shall be in detail on a printed incident report form. (III)
- c. The person in charge at the time of the incident shall prepare and sign the report. (III)
- d. The report shall cover all accidents where there is apparent injury or where hidden injury may have occurred. (III)
- e. The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)
- f. A copy of the incident report shall be kept on file in the facility. (III)

58.15(5) Retention of records.

- a. Records shall be retained in the facility for five years following termination of services. (III)
- b. Records shall be retained within the facility upon change of ownership. (III)
- c. Rescinded, effective 7/14/82.
- d. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

58.15(6) Reports to the department. The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

58.15(7) Personnel record.

a. An employment record shall be kept for each employee, consisting of the following information: name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home, criminal history and dependent adult abuse background checks, and date and reason for discharge or resignation. (III)

- b. The personnel records shall be made available for review upon request by the department. (III)

481—58.16(135C) Resident care and personal services.

58.16(1) Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

58.16(2) Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

58.16(3) Residents shall have clean clothing as needed to present a neat appearance, to be free of odors, and to be comfortable. Clothing shall be based on resident choice and shall be appropriate to residents' activities and to the weather. (III)

58.16(4) Rescinded, effective 7/14/82.

58.16(5) Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

58.16(6) Residents shall not be required to pass through another's bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

58.16(7) Rescinded, effective 7/14/82.

58.16(8) Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

58.16(9) Except for those who request differently, residents who are not bedfast shall be fully dressed each day to maintain self-esteem and promote the residents' normal lifestyles. (III)

58.16(10) Residents shall receive a bath of their choice, based on the facility's accommodations, as needed to maintain proper hygiene. (II, III)

481—58.17 Rescinded, effective 7/14/82.

481—58.18(135C) Nursing care.

58.18(1) Individual health care plans shall be based on resident treatment decisions, the nature of the illness or disability, treatment, and care prescribed. Goals shall be developed by each discipline providing service, treatment, and care. These plans shall be in writing, revised as necessary, and kept current. They shall be made available to all those rendering the services and for review by the department. (III)

58.18(2) Residents shall be protected against hazards to themselves and others or the environment. (II, III)

58.18(3) The facility shall provide resident and family education as an integral part of restorative and supportive care. (III)

58.18(4) The facility shall provide prompt response from qualified staff for the resident's use of the nurse call system. (II, III) (Prompt response being considered as no longer than 15 minutes.)

481—58.19(135C) Required nursing services for residents. The program plan for nursing facilities shall have the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:

58.19(1) Activities of daily living.

- a. Bathing; (II, III)
 - b. Daily oral hygiene (denture care); (II, III)
 - c. Routine shampoo; (II, III)
 - d. Nail care; (III)
 - e. Shaving; (III)
 - f. Daily care and application of prostheses (glasses, hearing aids, glass eyes, limb prosthetics, braces, or other assistive devices); (II, III)
 - g. Ambulation with equipment if applicable, or transferring, or positioning; (I, II, III)
 - h. Daily routine range of motion; (II, III)
 - i. Mobility (assistance with wheelchair, mechanical lift, or other means of locomotion); (I, II, III)
 - j. Elimination.
 - (1) Assistance to and from the bathroom and perineal care; (II, III)
 - (2) Bedpan assistance; (II, III)
 - (3) Care for incontinent residents; (II, III)
 - (4) Bowel and bladder training programs including in-dwelling catheter care (i.e., insertion and irrigation), enema and suppository administration, and monitoring and recording of intake and output, including solid waste; (I, II, III)
 - k. Colostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)
 - l. Ileostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)
 - m. All linens necessary; (III)
 - n. Nutrition and meal service.
 - (1) Regular, therapeutic, modified diets, and snacks; (I, II, III)
 - (2) Mealtime preparation of resident; (II, III)
 - (3) Assistance to and from meals; (II, III)
 - (4) In-room meal service or tray service; (II, III)
 - (5) Assistance with food preparation and meal assistance including total assistance if needed; (II, III)
 - (6) Assistance with adaptive devices; (II, III)
 - (7) Enteral nutrition (to be performed by a registered nurse or licensed practical nurse only); (I, II, III)
 - o. Promote initiation of self-care for elements of resident care; (II, III)
 - p. Oral suctioning (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse). (I, II)
- 58.19(2) Medication and treatment.**
- a. Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (I, II)
 - b. Wound care; (I, II)
 - c. Blood glucose monitoring; (I, II)
 - d. Vital signs, blood pressure, and weights; (I, II)

- e.* Ambulation and transfer; (II, III)
- f.* Provision of restraints; (I, II)
- g.* Administration of oxygen (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II)
- h.* Provision of all treatments; (I, II, III)
- i.* Provision of emergency medical care, including arranging for transportation, in accordance with written policies and procedures of the facility; (I, II, III)
- j.* Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III)

481—58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:

- 58.20(1)** Direct the implementation of the physician's orders; (I, II)
- 58.20(2)** Plan for and direct the nursing care, services, treatments, procedures, and other services in order that each resident's needs and choices, where practicable, are met; (II, III)
- 58.20(3)** Review the health care needs and choices, where practicable, of each resident admitted to the facility and assist the attending physician in planning for the resident's care; (II, III)
- 58.20(4)** Develop and implement a written health care plan in cooperation with, to the extent practicable, the resident, the resident's family or the resident's legal representative, and others in accordance with instructions of the attending physician as follows:
 - a.* The written health care plan, based on the assessment and reassessment of the resident's health needs and choices, where practicable, is personalized for the individual resident and indicates care to be given, goals to be accomplished, and methods, approaches, and modifications necessary to achieve best results; (III)
 - b.* The health service supervisor is responsible for preparing, reviewing, supervising the implementation, and revising the written health care plan; (III)
 - c.* The health care plan is readily available for use by all personnel caring for the resident; (III)
- 58.20(5)** Initiate preventative and restorative nursing procedures for each resident so as to achieve and maintain the highest possible degree of function, self-care, and independence based on resident choice, where practicable; (II, III)
- 58.20(6)** Supervise health services personnel to ensure they perform the following restorative measures in their daily care of residents:
 - a.* Maintaining good bodily alignment and proper positioning; (II, III)
 - b.* Making every effort to keep the resident active except when contraindicated by physician's orders, and encouraging residents to achieve independence in activities of daily living by teaching self-care, transfer, and ambulation activities; (III)
 - c.* Assisting residents to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests as necessary; (III)
 - d.* Assisting residents to carry out prescribed therapy exercises between visits of the therapist; (III)
 - e.* Assisting residents with routine range of motion exercises; (III)
- 58.20(7)** Plan and conduct nursing staff orientation and in-service programs and provide for training of nurse's aides; (III)
- 58.20(8)** Plan with the resident and the resident's physician and family and health-related agencies for the care of the resident upon discharge; (III)
- 58.20(9)** Designate a responsible person to be in charge during absences; (III)
- 58.20(10)** Be responsible for all assignments and work schedules for all health services personnel to ensure that the health needs of the residents are met; (III)
- 58.20(11)** Ensure that all nurse's notes are descriptive of the care rendered including the resident's response; (III)
- 58.20(12)** Visit each resident routinely to be knowledgeable of the resident's current condition; (III)
- 58.20(13)** Evaluate in writing the performance of each individual on the health care staff on at least an annual basis. This evaluation shall be available for review in the facility to the department; (III)

58.20(14) Keep the administrator informed of the resident's status; (III)

58.20(15) Teach and coordinate rehabilitative health care including activities of daily living, promotion and maintenance of optimal physical and mental functioning; (III)

58.20(16) Supervise serving of meals to ensure that individuals unable to assist themselves are promptly fed and that special eating adaptive devices are available as needed; (II, III)

58.20(17) Make available a nursing procedure manual which shall include all procedures practiced in the facility; (III)

58.20(18) Participate with the administrator in the formulation of written policies and procedures for resident services; (III)

58.20(19) The person in charge shall immediately notify the family of any accident, injury, or adverse change in the resident's condition requiring physician's notification. (III)

481—58.21(135C) Drugs, storage, and handling.

58.21(1) Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

a. A cabinet with a lock, convenient to nursing service, shall be provided and used for storage of all drugs, solutions, and prescriptions; (III)

b. The drug storage cabinet shall be kept locked when not in use; (III)

c. The medication cabinet key shall be in the possession of the person directly responsible for issuing medications; (II, III)

d. Double-locked storage of Schedule II drugs shall not be required under single unit package drug distribution systems in which the quantity stored does not exceed a three-day supply and a missing dose can be readily detected. (II)

58.21(2) Drugs for external use shall be stored separately from drugs for internal use. (III)

58.21(3) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items. A method for locking these medications shall be provided. (III)

58.21(4) All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons. (I, II)

58.21(5) All flammable materials shall be specially stored and handled in accordance with applicable local and state fire regulations. (II)

58.21(6) A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

a. The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

b. This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

c. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved nurse aide course, nurse aide training and testing program or nurse aide competency examination.

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

d. A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

(4) Successfully complete a department-approved nurse aide competency evaluation.

e. A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph "c" of this subrule do not apply to this individual.

58.21(7) Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day that they are administered, (II) unless the unit dose system is used.

58.21(8) An accurate written record of medications administered shall be made by the individual administering the medication. (III)

58.21(9) Records shall be kept of all Schedule II drug medications received and dispensed in accordance with the controlled drug and substance Act. (III)

58.21(10) Any unusual resident reaction shall be reported to the physician at once. (II)

58.21(11) A policy shall be established by the facility in conjunction with a licensed pharmacist to govern the distribution of prescribed medications to residents who are on leave from the facility. (III)

a. Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 58.21(14) "a," non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident's name, the facility, the medication, its strength, dose, and time of administration.

b. Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

c. Medication distributed as above may be issued only by a nurse responsible for administering medication. (I, II, III)

58.21(12) Emergency medications. A nursing facility shall provide emergency medications pursuant to the following requirements: (III)

a. Prescription drugs as well as nonprescription items must be prescribed or approved by the physician, in consultation with the pharmacist, who provides emergency service to the facility; (III)

b. The emergency medications shall be stored in an accessible place; (III)

c. A list of the emergency medications and quantities of each item shall be maintained by the facility; (III)

d. The container holding the emergency medications shall be closed with a seal which may be broken when drugs are required in an emergency or for inspection; (III)

e. Any item removed from the emergency medications shall be replaced within 48 hours; (III)

f. A permanent record shall be kept of each time the emergency medications are used; (III)

g. The emergency medications shall be inspected by a pharmacist at least once every three months to determine the stability of items. (III)

58.21(13) Drug handling.

a. Bulk supplies of prescription drugs shall not be kept in a nursing facility unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

b. Inspection of drug storage condition shall be made by the health service supervisor and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the nurse and pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician's order, and drugs improperly stored. (III)

c. If the facility permits licensed nurses to dilute or reconstitute drugs at the nursing station, distinctive supplementary labels shall be available for the purpose. The notation on the label shall be so made as to be indelible. (III)

d. Dilution and reconstitution of drugs and their labeling shall be done by the pharmacist whenever possible. If not possible, the following shall be carried out only by the licensed nurse:

(1) Specific directions for dilution or reconstitution and expiration date should accompany the drug; (III)

(2) A distinctive supplementary label shall be affixed to the drug container when diluted or reconstituted by the nurse for other than immediate use. (III) The label shall bear the following: resident's name, dosage and strength per unit/volume, nurse's name, expiration date, and date and time of dilution. (III)

58.21(14) Drug safeguards.

a. All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III)

b. Medication containers having soiled, damaged, illegible or makeshift labels, or medication samples shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

c. There shall be no medications or any solution in unlabeled containers. (II, III)

d. The medications of each resident shall be kept or stored in the originally received containers. (II, III)

e. Labels on containers shall be clearly legible and firmly affixed. No label shall be superimposed on another label of a drug container. (II, III)

f. When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

g. Unused prescription drugs prescribed for residents who are deceased shall be returned to the supplying pharmacist. (III)

h. Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

i. No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

j. Instructions shall be requested of the Iowa board of pharmacy examiners concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

k. There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by the responsible nurse with a witness and a notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy examiners. (II, III)

l. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The physician, in consultation with the pharmacist serving the home, shall institute policies and provide procedures for review and endorsement of stop orders on drugs. This policy shall be conveniently located for personnel administering medications. (II, III)

m. No resident shall be allowed to keep possession of any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

n. Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in their bedroom, but locked storage must be provided. (II)

o. No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

p. A qualified nurse shall:

(1) Establish a medication schedule system which identifies the time and dosage of each medication prescribed for each resident, is based on the resident's desired routine, and is approved by the resident's physician. (II, III)

(2) Establish a medication record containing the information specified above needed to monitor each resident's drug regimen. (II, III)

q. Telephone orders shall be taken by a qualified nurse. Orders shall be written into the resident's record and signed by the person receiving the order. Telephone orders shall be submitted to the physician for signature within 48 hours. (III)

r. A pharmacy operating in connection with a nursing facility shall comply with the provisions of the pharmacy law requiring registration of pharmacies and the regulations of the Iowa board of pharmacy examiners. (III)

s. In a nursing facility with a pharmacy or drug supply, service shall be under the personal supervision of a pharmacist licensed to practice in the state of Iowa. (III)

58.21(15) Drug administration.

a. Injectable medications shall not be administered by anyone other than a qualified nurse or physician. In the case of a resident who has been certified by the resident's physician as capable of taking the resident's own insulin, the resident may inject the resident's own insulin. (II)

b. An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

c. The health service supervisor shall be responsible for the supervision and direction of all personnel administering medications. (II)

481—58.22(135C) Rehabilitative services. Rehabilitative services shall be provided to maintain function or improve the resident's ability to carry out the activities of daily living.

58.22(1) Physical therapy services.

a. Each facility shall have a written agreement with a licensed physical therapist to provide physical therapy services. (III)

b. Physical therapy shall be rendered only by a physical therapist licensed to practice in the state of Iowa. All personnel assisting with the physical therapy of residents must be under the direction of a licensed physical therapist. (II, III)

c. The licensed physical therapist shall:

(1) Evaluate the resident and prepare a physical therapy treatment plan conforming to the medical orders and goals; (III)

(2) Consult with other personnel in the facility who are providing resident care and plan with them for the integration of a physical therapy treatment program into the overall health care plan; (III)

(3) Instruct the nursing personnel responsible for administering selected restorative procedures between treatments; (III)

(4) Present programs in the facility's in-service education programs. (III)

d. Treatment records in the resident's medical chart shall include:

(1) The physician's prescription for treatment; (III)

(2) An initial evaluation note by the physical therapist; (III)

(3) The physical therapy care plan defining clearly the long-term and short-term goals and outlining the current treatment program; (III)

(4) Notes of the treatments given and changes in the resident's condition; (III)

(5) A complete discharge summary to include recommendations for nursing staff and family. (III)

e. There shall be adequate facilities, space, appropriate equipment, and storage areas as are essential to the treatment or examinations of residents. (III)

58.22(2) Other rehabilitative services.

a. The facility shall arrange for specialized and supportive rehabilitative services when such services are ordered by a physician. (III) These may include audiology and occupational therapy.

- b.* Audiology services shall be under the direction of a person licensed in the state of Iowa by the board of speech pathology and audiology. (II, III)
- c.* Occupational therapy services shall be under the direction of a qualified occupational therapist who is currently registered by the American Occupational Therapy Association. (II, III)
- d.* The appropriate professional shall:
 - (1) Develop the treatment plan and administer or direct treatment in accordance with the physician's prescription and rehabilitation goals; (III)
 - (2) Consult with other personnel within the facility who are providing resident care and plan with them for the integration of a treatment program into the overall health care plan. (III)

481—58.23(135C) Dental, diagnostic, and other services.**58.23(1) Dental services.**

- a.* The nursing facility personnel shall assist residents to obtain regular and emergency dental services. (III)
- b.* Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)
- c.* Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)
- d.* All dental reports or progress notes shall be included in the clinical record. (III)
- e.* Nursing personnel shall assist the resident in carrying out dentist's recommendations. (III)
- f.* Dentists shall be asked to participate in the in-service program of the facility. (III)

58.23(2) Diagnostic services.

- a.* The nursing facility shall make provisions for promptly securing required clinical laboratory, X-ray, and other diagnostic services. (III)
- b.* All diagnostic services shall be provided only on the written, signed order of a physician. (III)
- c.* Agreements shall be made with the local hospital laboratory or independent laboratory to perform specific diagnostic tests when they are required. (III)
- d.* Transportation arrangements for residents shall be made, when necessary, to and from the source of service. (III)
- e.* Copies of all diagnostic reports shall be requested by the facility and included in the resident's clinical record. (III)
- f.* The physician ordering the specific diagnostic service shall be promptly notified of the results. (III)
- g.* Simple tests such as customarily done by nursing personnel for diabetic residents may be performed in the facility. (III)

58.23(3) Other services.

- a.* The nursing facility shall assist residents to obtain such supportive services as requested by the physician. (III)
- b.* Transportation arrangements shall be made when necessary. (III)
- c.* Services could include the need for prosthetic devices, glasses, hearing aids, and other necessary items. (III)

481—58.24(135C) Dietary.

58.24(1) Organization of dietetic services. The facility shall meet the needs of the residents and provide the services listed in this standard. If the service is contracted out, the contractor shall meet the same standard. A written agreement shall be formulated between the facility and the contractor and shall convey to the department the right to inspect the food service facilities of the contractor. (III)

- a.* There shall be written policies and procedures for dietetic services that include staffing, nutrition, menu planning, therapeutic diets, preparation, service, ordering, receiving, storage, sanitation, and staff hygiene. The policies and procedures shall be made available for use by dietetic services. (III)
- b.* There shall be written job descriptions for each position in dietetic services. The job descriptions shall be made available for use by dietetic services. (III)

58.24(2) Dietary staffing.

a. The facility shall employ a qualified dietary supervisor who:

(1) Is a qualified dietitian as defined in 58.24(2)“e”; or

(2) Is a graduate of a dietetic technician training program approved by the American Dietetic Association; or

(3) Is a certified dietary manager certified by the certifying board for dietary managers of the Dietary Managers Association (DMA) and maintains that credential through 45 hours of DMA-approved continuing education; or

(4) Has completed a DMA-approved course curriculum necessary to take the certification examination required to become a certified dietary manager; or

(5) Has documented evidence of at least two years' satisfactory work experience in food service supervision and who is in an approved dietary manager association program and will successfully complete the program within 12 months of the date of enrollment; or

(6) Has completed or is in the final 90-hour training course approved by the department. (II, III)

b. The supervisor shall have overall supervisory responsibility for dietetic services and shall be employed for a sufficient number of hours to complete management responsibilities that include:

(1) Participating in regular conferences with consultant dietitian, administrator and other department heads; (III)

(2) Writing menus with consultation from the dietitian and seeing that current menus are posted and followed and that menu changes are recorded; (III)

(3) Establishing and maintaining standards for food preparation and service; (II, III)

(4) Participating in selection, orientation, and in-service training of dietary personnel; (II, III)

(5) Supervising activities of dietary personnel; (II, III)

(6) Maintaining up-to-date records of residents identified by name, location and diet order; (III)

(7) Visiting residents to learn individual needs and communicating with other members of the health care team regarding nutritional needs of residents when necessary; (II, III)

(8) Keeping records of repairs of equipment in dietetic services. (III)

c. The facility shall employ sufficient supportive personnel to carry out the following functions:

(1) Preparing and serving adequate amounts of food that are handled in a manner to be bacteriologically safe; (II, III)

(2) Washing and sanitizing dishes, pots, pans and equipment at temperatures required by procedures described elsewhere; (II, III)

(3) Serving of therapeutic diets as prescribed by the physician and following the planned menu. (II, III)

d. The facility may assign simultaneous duties in the kitchen and laundry, housekeeping, or nursing service to appropriately trained personnel. Proper sanitary and personal hygiene procedures shall be followed as outlined under the rules pertaining to staff hygiene. (II, III)

e. If the dietetic service supervisor is not a licensed dietitian, a consultant dietitian is required. The consultant dietitian shall be licensed by the state of Iowa pursuant to Iowa Code chapter 152A.

f. Consultants' visits shall be scheduled to be of sufficient duration and at a time convenient to:

(1) Record, in the resident's medical record, any observations, assessments and information pertinent to medical nutrition therapy; (I, II, III)

(2) Work with residents and staff on resident care plans; (III)

(3) Consult with the administrator and others on developing and implementing policies and procedures; (III)

(4) Write or approve general and therapeutic menus; (III)

(5) Work with the dietetic supervisor on developing procedures, recipes and other management tools; (III)

(6) Present planned in-service training and staff development for food service employees and others. Documentation of consultation shall be available for review in the facility by the department. (III)

g. In facilities licensed for more than 15 beds, dietetic services shall be available for a minimum of a 12-hour span extending from the time of preparation of breakfast through supper. (III)

58.24(3) Nutrition and menu planning.

a. Menus shall be planned and followed to meet the nutritional needs of each resident in accordance with the physician's orders and in consideration of the resident's choices and preferences. (II, III)

b. Menus shall be planned to provide 100 percent of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. A current copy of the Simplified Diet Manual published by Blackwell Publishing, Ames, Iowa, shall be available and used in the planning and serving of all meals. (II)

c. At least three meals or their equivalent shall be served daily, at regular hours comparable to normal mealtimes in the community. (II)

(1) There shall be no more than a 14-hour span between a substantial evening meal and breakfast except as provided in subparagraph (3) below. (II, III)

(2) The facility shall offer snacks at bedtime daily. (II, III)

(3) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast of the following day. The current resident group must agree to this meal span and a nourishing snack must be served. (II)

d. Menus shall include a variety of foods prepared in various ways. The same menu shall not be repeated on the same day of the following week. (III)

e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing and serving food. (III)

f. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by department personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded. (III)

g. A file of tested recipes adjusted to the number of people to be served in the facility shall be maintained. (III)

h. Alternate foods shall be offered to residents who refuse the food served. (II, III)

58.24(4) Therapeutic diets.

a. Therapeutic diets shall be prescribed by the attending physician. A current therapeutic diet manual shall be readily available to attending physicians, nurses and dietetic service personnel. This manual shall be used as a guide for writing menus for therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and reviewing procedures for preparation and service of food. (III)

b. Personnel responsible for planning, preparing and serving therapeutic diets shall receive instructions on those diets. (III)

58.24(5) Food preparation and service.

a. Methods used to prepare foods shall be those which conserve nutritive value and flavor and meet the taste preferences of the residents. (III)

b. Foods shall be attractively served. (III)

c. Foods shall be cut up, chopped, ground or blended to meet individual needs. (II, III)

d. Self-help devices shall be provided as needed. (II, III)

e. Table service shall be attractive. (III)

f. Plasticware, china and glassware that are unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze shall be discarded. (III)

g. All food that is transported through public corridors shall be covered. (III)

h. All potentially hazardous food or beverages capable of supporting rapid and progressive growth of microorganisms that can cause food infections or food intoxication shall be maintained at temperatures of 41°F or below or at 140°F or above at all times, except during necessary periods of preparation. Frozen food shall be maintained frozen. (I, II, III)

i. Potentially hazardous food that is cooked, cooled and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165°F for 15 seconds. (I, II, III)

j. Food must be reheated to 165°F within no more than two hours after the heating process begins. (I, II, III)

k. Cooked potentially hazardous food shall be cooled:

(1) Within two hours, from 140°F to 70°F; and

(2) Within four hours, from 70°F to 41°F or less. (I, II, III)

58.24(6) Dietary ordering, receiving, and storage.

a. All food and beverages shall be of wholesome quality and procured from sources approved or considered satisfactory by federal, state and local authorities. Food or beverages from unlabeled, rusty, leaking, broken or damaged containers shall not be served. (I, II, III)

b. A minimum of at least a one-week supply of staple foods and a three-day supply of perishable foods shall be maintained on the premises to meet the planned menu needs until the next food delivery. Supplies shall be appropriate to meet the requirements of the menu. (III)

c. All milk shall be pasteurized. (III)

d. Milk may be served in individual, single-use containers. Milk may be served from refrigerated bulk milk dispensers or from the original container. Milk served from a refrigerated bulk milk dispenser shall be dispensed directly into the glass or other container from which the resident drinks. (II, III)

e. Records which show amount and kind of food purchased shall be retained for three months and shall be made available to the department upon request. (III)

f. Dry or staple items shall be stored at least six inches (15 cm) above the floor in a ventilated room, not subject to sewage or wastewater backflow, and protected from condensation, leakage, rodents or vermin in accordance with the Food Code, 1999 edition. (III)

g. Pesticides, other toxic substances and drugs shall not be stored in the food preparation or storage areas used for food or food preparation equipment and utensils. Soaps, detergents, cleaning compounds or similar substances shall not be stored in food storage rooms or areas. (II)

h. Food storage areas shall be clean at all times. (III)

i. There shall be a reliable thermometer in each refrigerator, freezer and in storerooms used for food. (III)

j. Foods held in refrigerated or other storage areas shall be appropriately covered. Food that was prepared and not served shall be stored appropriately, clearly identifiable and dated. (III)

58.24(7) Sanitation in food preparation area.

a. Unless otherwise indicated in this chapter or 481—Chapter 61, the sanitary provisions as indicated in Chapters 3, 4 and 7 of the 1999 Food Code, U.S. Public Health Service, Food and Drug Administration, Washington, DC 20204, shall apply.

b. Residents may be allowed in the food preparation area. (III)

c. The food preparation area may be used as a dining area for residents, staff or food service personnel. (III)

d. All food service areas shall be kept clean, free from litter and rubbish, and protected from rodents, animals, roaches, flies and other insects. (II, III)

e. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair, and shall be free from breaks, corrosion, cracks and chipped areas. (II, III)

f. There shall be effective written procedures established for cleaning all work and serving areas. (III)

g. A schedule of cleaning duties to be performed daily shall be posted. (III)

h. An exhaust system and hood shall be clean, operational and maintained in good repair. (III)

i. Spillage and breakage shall be cleaned up immediately and disposed of in a sanitary manner. (III)

j. Wastes from the food service that are not disposed of by mechanical means shall be kept in leakproof, nonabsorbent, tightly closed containers when not in immediate use and shall be disposed of frequently. (III)

k. The food service area shall be located so it will not be used as a passageway by residents, guests or non-food service staff. (III)

l. The walls, ceilings and floors of all rooms in which food is prepared and served shall be in good repair, smooth, washable, and shall be kept clean. Walls and floors in wet areas should be moisture-resistant. (III)

m. Ice shall be stored and handled in such a manner as to prevent contamination. Ice scoops should be sanitized daily and kept in a clean container. (III)

n. There shall be no animals or birds in the food preparation area. (III)

o. All utensils used for eating, drinking, and preparing and serving food and drink shall be cleaned and disinfected or discarded after each use. (III)

p. If utensils are washed and rinsed in an automatic dishmachine, one of the following methods shall be used:

(1) When a conventional dishmachine is utilized, the utensils shall be washed in a minimum of 140°F using soap or detergent and sanitized in a hot water rinse of not less than 170°F. (II, III)

(2) When a chemical dishmachine is utilized, the utensils shall be washed in a minimum of 120°F using soap or detergent and sanitized using a chemical sanitizer that is automatically dispensed by the machine and is in a concentration equivalent to 50 parts per million (ppm) available chloride. (II, III)

q. If utensils are washed and rinsed in a three-compartment sink, the utensils shall be thoroughly washed in hot water at a minimum temperature of 110°F using soap or detergent, rinsed in hot water to remove soap or detergent, and sanitized by one of the following methods:

(1) Immersion for at least 30 seconds in clean water at 180°F; (II, III)

(2) Immersion in water containing bactericidal chemical at a minimum concentration as recommended by the manufacturer. (II, III)

r. After sanitation, the utensils shall be allowed to drain and dry in racks or baskets on nonabsorbent surfaces. Drying cloths shall not be used. (III)

s. Procedures for washing and handling dishes shall be followed in order to protect the welfare of the residents and employees. Persons handling dirty dishes shall not handle clean dishes without first washing their hands. (III)

t. A mop and mop pail shall be provided for exclusive use in kitchen and food storage areas. (III)

58.24(8) Hygiene of food service personnel.

a. Personnel, if involved in dietetic services, shall be trained in basic food sanitation techniques, shall be clean and wear clean clothing, including a cap or a hairnet sufficient to contain, cover and restrain hair. Beards, mustaches and sideburns that are not closely cropped and neatly trimmed shall be covered. (III)

b. Personnel shall be excluded from duty when affected by skin infections or communicable diseases in accordance with the facility's infection control policies. (II, III)

c. Employee street clothing stored in the food service area shall be in a closed area. (III)

d. Food preparation sinks shall not be used for hand washing. Separate hand-washing facilities with soap, hot and cold running water, and single-use towels shall be used properly. (II, III)

e. The use of tobacco shall be prohibited in the food preparation area. (III)

58.24(9) Paid nutritional assistants. A paid nutritional assistant means an individual who meets the requirements of this subrule and who is an employee of the facility or an employee of a temporary employment agency employed by the facility. A facility may use an individual working in the facility as a paid nutritional assistant only if that individual has successfully completed a state-approved training program for paid nutritional assistants. (I, II, III)

a. Training program requirements.

(1) A state-approved training program for paid nutritional assistants must include, at a minimum, eight hours of training in the following areas:

1. Feeding techniques.
2. Assistance with feeding and hydration.
3. Communication and interpersonal skills.
4. Appropriate responses to resident behavior.

5. Safety and emergency procedures, including the Heimlich maneuver.
6. Infection control.
7. Resident rights.
8. Recognizing changes in residents that are inconsistent with their normal behavior and reporting these changes to the supervisory nurse.

(2) In addition to the training program requirements specified above, the training program must include at least four hours of classroom study, two hours of supervised laboratory work, and two hours of supervised clinical experience.

(3) A facility that offers a paid nutritional assistant training program must provide sufficient supplies in order to teach the objectives of the course.

(4) All paid nutritional assistant training program instructors shall be registered nurses. Other qualified health care professionals may assist the instructor in teaching the classroom portion and clinical or laboratory experiences. The ratio of students to instructor shall not exceed ten students per instructor in the clinical setting.

(5) Each individual enrolled in a paid nutritional assistant training program shall complete a 50-question multiple choice written test and must obtain a score of 80 percent or higher. In addition, the individual must successfully perform the feeding of a resident in a clinical setting. A registered nurse shall conduct the final competency determination.

(6) If an individual does not pass either the written test or competency demonstration, the individual may retest the failed portion a second time. If the individual does not pass either the written test or competency demonstration portion the second time, the individual shall not be allowed to retest.

b. Program approval. A facility or other entity may not offer or teach a paid nutritional assistant training program until the department has approved the program. Individuals trained in a program not approved by the department will not be allowed to function as paid nutritional assistants.

(1) A facility or other institution offering a paid nutritional assistant training program must provide the following information about the training program to the department before offering the program or teaching paid nutritional assistants:

1. Policies and procedures for program administration.
2. Qualifications of the instructors.
3. Maintenance of program records, including attendance records.
4. Criteria for determining competency.
5. Program costs and refund policies.
6. Lesson plans, including the objectives to be taught, skills demonstrations, assignments, quizzes, and classroom, laboratory and clinical hours.

(2) The facility or other institution offering a paid nutritional assistant training program must submit the materials specified above for department review. The department shall, within ten days of receipt of the material, advise the facility or institution whether the program is approved, or request additional information to assist the department in determining whether the curriculum meets the requirements for a paid nutritional assistant training program. Before approving any paid nutritional assistant training program, the department shall determine whether the curriculum meets the requirements specified in this subrule. The department shall maintain a list of facilities and institutions eligible to provide paid nutritional assistant training. (I, II, III)

(3) A facility shall maintain a record of all individuals who have successfully completed the required training program and are used by the facility as paid nutritional assistants. The individual shall complete the training program with a demonstration of knowledge and competency skills necessary to serve as a paid nutritional assistant. (I, II, III)

(4) Upon successful completion of the training program, the facility or other institution providing the training shall, within ten calendar days, provide the individual with a signed and dated certificate of completion. A facility that employs paid nutritional assistants shall maintain on file copies of the completed certificate and skills checklist for each individual who has successfully completed the training program. (I, II, III)

c. Working restrictions.

(1) A paid nutritional assistant must work under the supervision of a registered nurse or a licensed practical nurse. In an emergency, a paid nutritional assistant must call a supervisory nurse for help on the resident call system. (I, II, III)

(2) A facility must ensure that a paid nutritional assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube, parenteral or intravenous feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. (I, II, III)

481—58.25(135C) Social services program.

58.25(1) The administrator or designee shall be responsible for developing a written, organized orientation program for all residents. (III)

58.25(2) The program shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the medical or health care, recovery, and rehabilitation of the individual. (III)

58.25(3) The social services plan, including specific goals and regular evaluation of progress, shall be incorporated into the overall plan of care. (III)

481—58.26(135C) Resident activities program.

58.26(1) *Organized activities.* Each nursing facility shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

a. The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

b. The program shall include individual goals for each resident. (III)

c. The program shall include both group and individual activities. (III)

d. No resident shall be forced to participate in the activity program. (III)

e. The activity program shall include suitable activities for those residents unable to leave their rooms. (III)

f. The program shall be incorporated into the overall health plan and shall be designed to meet the goals as written in the plan.

58.26(2) *Coordination of activities program.*

a. Each nursing facility shall employ a person to direct the activities program. (III)

b. Staffing for the activity program shall be provided on the minimum basis of 35 minutes per licensed bed per week. (II, III)

c. The activity coordinator shall have completed the activity coordinators' orientation course offered through the department within six months of employment or have comparable training and experience as approved by the department. (III)

d. The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

e. There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

58.26(3) *Duties of activity coordinator.* The activity coordinator shall:

a. Have access to all residents' records excluding financial records; (III)

b. Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)

c. Keep all necessary records including:

(1) Attendance; (III)

(2) Individual resident progress notes recorded at regular intervals (at least quarterly). A copy of these notes shall be placed in the resident's clinical record; (III)

(3) Monthly calendars, prepared in advance. (III)

- d. Coordinate the activity program with all other services in the facility; (III)
- e. Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

58.26(4) Supplies, equipment, and storage.

- a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III) These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc.
- b. Storage shall be provided for recreational equipment and supplies. (III)
- c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

¹ Emergency, pursuant to Iowa Code section 17A.5(2)“b”(2).

² Objection filed 2/14/79; see Objection following 481—Ch 57.

481—58.27(135C) Resident advocate committee. Each facility shall have a resident advocate committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for resident advocate committees promulgated by the department on aging. (II)

58.27(1) Role of committee in complaint investigations.

- a. The department shall notify the facility’s resident advocate committee of a complaint from the public. The department shall not disclose the name of a complainant.
- b. The department may refer complaints to the resident advocate committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department on aging. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation or the investigation.
- c. When the department investigates a complaint, upon conclusion of its investigation, it shall notify the resident advocate committee and the department on aging of its findings, including any citations and fines issued.
- d. Results of all complaint investigations addressed by the resident advocate committee shall be forwarded to the department within ten days of completion of the investigation.

58.27(2) The resident advocate committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

58.27(3) When requested, names, addresses and telephone numbers of family members shall be given to the resident advocate committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the family member’s name, address or telephone number given to the resident advocate committee.

This rule is intended to implement Iowa Code section 135C.25.

481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

58.28(1) Fire safety.

- a. All nursing facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)
- b. The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

58.28(2) Safety duties of administrator. The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)

- a. The plan shall be posted. (III)
- b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

58.28(3) Resident safety.

- a. Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when the resident is under direct supervision. (II, III)
- b. Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)
- c. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)
- d. Smoking shall be permitted only in posted areas. (II, III)
- e. Each resident shall receive adequate supervision to ensure against hazard from self, others, or elements in the environment. (II, III)

481—58.29(135C) Resident care.

58.29(1) There shall be a readily available supply of self-help and ambulation devices such as wheelchairs, walkers, and such other devices maintained in good repair that will meet the current needs of all residents. (III)

58.29(2) The facility shall ensure that each ambulatory resident has well-fitting shoes to provide support and prevent slipping. (III)

58.29(3) Equipment for personal care shall be maintained in a safe and sanitary condition. (II, III)

58.29(4) The expiration date for sterile equipment shall be exhibited on its wrappings. (III)

58.29(5) Residents who have been known to wander shall be provided with appropriate means of identification. (II, III)

58.29(6) Electric heating pads, blankets, or sheets shall be used only on the written order of a physician, when allowed by the Life Safety Code or applicable state or local fire regulations. (II, III)

481—58.30 Rescinded, effective 7/14/82.

481—58.31(135C) Housekeeping.

58.31(1) Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

58.31(2) Each resident unit shall be cleaned on a routine schedule. (III)

58.31(3) All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

58.31(4) A hallway or corridor shall not be used for storage of equipment. (III)

58.31(5) All odors shall be kept under control by cleanliness and proper ventilation. (III)

58.31(6) Clothing worn by personnel shall be clean and washable. (III)

58.31(7) Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

58.31(8) All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

58.31(9) Polishes used on floors shall provide a nonslip finish. (III)

58.31(10) *Throw or scatter rugs shall not be permitted. (III)

*Objection. For text of Objection, see IAC Supp., Part I, 9/7/77. For text of Filed rules, 470—Chapter 58, see IAC Supp. 10/5/77.

58.31(11) Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

58.31(12) Residents shall not have access to storage areas for all cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials. (II, III)

58.31(13) Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

58.31(14) Definite procedures shall be established for training housekeeping personnel. (III)

58.31(15) Rescinded IAB 12/6/06, effective 1/10/07.

58.31(16) There shall be provisions for the cleaning and storage of housekeeping equipment and supplies for each nursing unit. (III)

58.31(17) Bathtubs, shower stalls, or lavatories shall not be used for laundering, cleaning of utensils and mops, or for storage. (III)

58.31(18) Bedside utensils shall be stored in enclosed cabinets. (III)

58.31(19) Kitchen sinks shall not be used for the cleaning of mops, soaking of laundry, cleaning of bedside utensils, nursing utensils, or dumping of wastewater. (III)

58.31(20) Personal possessions of residents which may constitute hazards to themselves or others shall be removed and stored. (III)

481—58.32(135C) Maintenance.

58.32(1) Each facility shall establish a maintenance program in writing to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. (III)

58.32(2) The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

58.32(3) Draperies and furniture shall be clean and in good repair. (III)

58.32(4) Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

58.32(5) The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the national electrical code. (III)

58.32(6) All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

58.32(7) Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. Documentation of these inspections shall be available for review. (III)

58.32(8) The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

58.32(9) The facility shall be kept free of flies, other insects, and rodents. (III)

58.32(10) Maintenance personnel.

a. A written program shall be established for the orientation of maintenance personnel. (III)

b. Maintenance personnel shall:

(1) Follow established written maintenance programs; (III)

(2) Be provided with appropriate, well-constructed, and properly maintained equipment. (III)

481—58.33(135C) Laundry.

58.33(1) All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

58.33(2) Except for related activities, the laundry room shall not be used for other purposes. (III)

58.33(3) Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

58.33(4) Residents' personal laundry shall be marked with an identification. (III)

58.33(5) Bed linens, towels, and washcloths shall be clean and stain-free. (III)

481—58.34(135C) Garbage and waste disposal.

58.34(1) All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

58.34(2) All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

58.34(3) All containers shall be thoroughly cleaned each time the containers are emptied. (III)

58.34(4) All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

58.34(5) Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

481—58.35(135C) Buildings, furnishings, and equipment.

58.35(1) Buildings—general requirements.

a. For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than seven feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

b. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

c. All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

d. Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

e. Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

f. All fans located within seven feet of the floor shall be protected by screen guards of not more than one-half-inch mesh. (III)

g. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

h. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

i. No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates, except closets used for the storage of residents' clothing. (III)

58.35(2) Furnishings and equipment.

a. All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a home-like atmosphere. (III)

c. Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

58.35(3) Dining and living rooms.

a. Every facility shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 58.35(3) "e" are met. (III)

e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment. (III)

f. Living rooms.

(1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)

(2) Living rooms shall be suitably provided with parlor furniture, television and radio receivers in good working order, recreational material such as games, puzzles, and cards, and reading material such as current newspapers and magazines. Furnishings and equipment of the room should be such as to allow group activities. (III)

(3) Card tables or game tables shall be made available. The tables should be of a height to allow a person seated in a wheelchair to partake in the games or card playing. (III)

(4) Chairs of proper height and appropriate to their use shall be provided for seating residents at game tables and card tables. (III)

g. Dining rooms.

(1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

(2) Dining tables and chairs shall be provided. (III)

(3) Dining tables should be so constructed that a person seated in a wheelchair can dine comfortably. (III)

(4) Tables shall be of sturdy construction with smooth, durable, nonpermeable tops that can be cleaned with a detergent sanitizing solution. (III)

(5) Dining chairs shall be sturdy and comfortable. Some arm chairs should be provided for ease of movement for some residents. (III)

(6) Residents shall be encouraged to eat in the dining room. (III)

58.35(4) *Bedrooms.*

a. Each resident shall be provided with a standard, single, or twin bed that is substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. Seventy-five percent of the beds shall have a spring with an adjustable head and foot section. A resident shall have the right to sleep in a chair per the resident's request and to have the bed removed from the room to allow for additional space. (III)

b. Each bed shall be equipped with the following: casters or glides unless a low bed and mattress are being used for fall precautions; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; clean, comfortable pillows of average size; and moisture-proof covers and sheets as necessary to keep the mattress and pillows dry and clean. (III)

c. Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)

d. There shall be a comfortable chair, either a rocking chair or armchair, per resident bed. The resident's personal wishes shall be considered. (III)

e. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

f. Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)

g. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

h. Clothing shall be hung in closets or wardrobes available in each room. (III)

i. Beds shall not be placed with the head of the bed in front of a window or radiator. (III)

j. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)

k. Reading lamps shall be provided each resident in the resident's room. (III)

l. Each room shall have sufficient accessible mirrors to serve the resident's needs. Mirrors are not required if the room is located in a CCDI unit and the mirrors cause concern for the resident. (III)

m. Sturdy, adjustable overbed tables shall be provided for each resident who is unable to eat in the dining room. (III)

n. Each resident bedroom shall have a door. The door shall be the swing type and shall not swing into the corridor. (III)

58.35(5) *Heating.* A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (III)

58.35(6) *Water supply.*

a. Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)

- b.* Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)
- c.* A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)
- d.* The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)
- e.* Hot and cold running water under pressure shall be available in the facility. (III)
- f.* Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department of health. (III)

58.35(7) Nonambulatory residents.

- a.* All nonambulatory residents shall be housed on the grade level floor. (II, III)
- b.* These provisions in “a” above relating to nonambulatory residents are not applicable if the facility has a suitably sized elevator.

481—58.36(135C) Family and employee accommodations.

58.36(1) Children under 14 years of age shall not be allowed into the service areas. (III)

58.36(2) The residents’ bedrooms shall not be occupied by employees or family members of the licensee. (III)

58.36(3) In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

58.36(4) In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

58.36(5) In all health care facilities, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

481—58.37(135C) Animals. Animals may be permitted within the facility with prior approval of the department and under controlled conditions. (III)

481—58.38(135C) Supplies.

58.38(1) Linen supplies.

a. There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

b. A complete change of bed linens shall be available in the linen storage area for each bed. (III)

c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)

d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

e. Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

58.38(2) First-aid kit. A first-aid emergency kit shall be available on each floor in every facility. (II, III)

58.38(3) Supplies and equipment for nursing services.

a. All nursing care equipment shall be properly sanitized or sterilized before use by another resident. (II)

b. There shall be disposable or one-time use items available with provisions for proper disposal to prevent reuse except as allowed by 58.10(8)“h,” 481—paragraph 59.12(10)“h,” or 481—paragraph 64.12(14)“h.” (I, II, III)

c. Convenient, safe storage shall be provided for bath and toilet supplies, bathroom scales, mechanical lifts, and shower chairs. (III)

d. Sanitary and protective storage shall be provided for all equipment and supplies. (III)

e. All items that must be sterilized shall be autoclaved unless sterile disposable items are furnished which are promptly disposed of after a single use. (III)

f. Supplies and equipment for nursing and personal care sufficient in quantities to meet the needs of the residents shall be provided and, as a minimum, include the following: (III)

Bath basins	Rectal tubes
Soap containers	Catheters and catheterization equipment
Denture cups	Douche nozzle
Emesis basins	Oxygen therapy equipment
Mouthwash cups	Naso-gastric feeding equipment
Bedpans	Wheelchairs
Urinals	Moisture-proof draw sheets
Enema equipment	Moisture-proof pillow covers
Commodes	Moisture-proof mattress covers
Quart graduate measure	Foot tubs
Thermometer for measurement of bath water temperature	Metal pitcher
Oral thermometer	Disinfectant solutions
Rectal thermometer	Alcohol
Basins for sterilizing thermometers	Lubricating jelly
Basins for irrigations	Skin lotion
Asepto syringes	Applicators
Sphygmomanometer	Tongue blades
Paper towels	Toilet paper
Paper handkerchiefs	Rubber gloves or disposable gloves
Insulin syringes	Scales for nonambulatory patients
2 cc hypodermic syringes	Tourniquet
Weight scales	Suction machine
Hypodermic needles	Medicine dispensing containers
Stethoscope	Bandages
Ice caps	Adhesive
Hot water bottles	Portable linen hampers
	Denture identification equipment
	Tracheotomy care equipment

481—58.39(135C) Residents' rights in general.

58.39(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 58.39(2) to 58.39(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

58.39(2) Policies and procedures shall address the admission and retention of persons with histories of dangerous or disturbing behavior. For the purposes of the subrule, persons with histories of dangerous or disturbing behavior are those persons who have been found to be seriously mentally impaired pursuant to Iowa Code section 229.13 or 812.1 within six months of the request for admission to the facility. In addition to establishing the criteria for admission and retention of persons so defined, the policies and procedures shall provide for:

a. Reasonable precautions to prevent the resident from harming self, other residents, or employees of the facility.

b. Treatment of persons with mental illness as defined in Iowa Code section 229.1(1) and which is provided in accordance with the individualized health care plan.

c. Ongoing and documented staff training on individualized health care planning for persons with mental illness.

58.39(3) Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

a. Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)

b. As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

58.39(4) Policies and procedures regarding the use of chemical and physical restraints shall define the use of said restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

58.39(5) Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

58.39(6) Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II)

58.39(7) Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies. (II)

a. The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

b. Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

c. A statement shall be signed by the resident, or the resident's responsible party, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party, if applicable. In the case of a mentally retarded resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

d. In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

e. All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English speaking, deaf, or blind residents of such changes. (II)

58.39(8) Each resident or responsible party shall be fully informed in a contract as required in rule 481—58.13(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges including any charges for services not covered under the Title XIX program or not covered by the facility's basic per diem rate. (II)

58.39(9) Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the

resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the U.S. Department of Health and Human Services protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or mentally retarded individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

a. The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either, shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

b. The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

c. If the physician determines or in the case of a confused or mentally retarded resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

d. The resident's plan of care shall be based on the physician's orders. It shall be developed upon admission by appropriate facility staff and shall include participation by the resident if capable. Residents shall be advised of alternative courses of care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives shall be elicited and honored if feasible.

e. Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended to December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

This rule is intended to implement Iowa Code section 135C.23(2).

481—58.40(135C) Involuntary discharge or transfer.

58.40(1) A facility shall not involuntarily discharge or transfer a resident from a facility except: for medical reasons; for the resident's welfare or that of other residents; for nonpayment for the resident's stay (as contained in the contract for the resident's stay), except as prohibited by Title XIX of the Social Security Act, 42 U.S.C. 1396 to 1396k by reason of action pursuant to Iowa Code chapter 229; by reason of negative action by the Iowa department of social services; and by reason of negative action by the professional standards review organization. A resident shall not be transferred or discharged solely because the cost of the resident's care is being paid under Iowa Code chapter 249A, or because the resident's source of payment is changing from private support to payment under chapter 249A. (I, II)

a. "Medical reasons" for transfer or discharge are based on the resident's needs and are determined and documented in the resident's record by the attending physician. Transfer or discharge may be required to provide a different level of care. In the case of transfer or discharge for the reason that the resident's condition has improved such that the resident no longer needs the level of care being provided by the facility, the determination that such medical reason exists is the exclusive province of the professional standards review organization or utilization review process in effect for residents whose care is paid in full or in part by Title XIX. (II)

b. "Welfare" of a resident or that of other residents refers to their social, emotional, or physical well-being. A resident might be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with the resident's needs and rights). Evidence that the resident's

continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall be in writing and shall include specific information to support this determination.

c. Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. The 30-day requirement shall not apply in any of the following instances:

(1) If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) If the transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility.

(3) If the discharge or transfer is the result of a final, nonappealable decision by the department of social services or the professional standards review organization.

d. The notice required by paragraph "*c*" shall contain all of the following information:

(1) The stated reason for the proposed transfer or discharge. (II)

(2) The effective date of the proposed transfer or discharge. (II)

(3) A statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department of inspections and appeals designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." (II)

e. A request for a hearing made under 58.40(1)"*d*"(3) shall stay a transfer or discharge pending a hearing or appeal decision. (II)

f. The type of hearing shall be determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the licensee, resident, responsible party, and Iowa department on aging long-term care ombudsman of record not later than five full business days after receipt of request. This notice shall also inform the licensee, resident or responsible party that they have a right to appear at the hearing in person or be represented by their attorneys or other individual. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department on aging long-term care ombudsman shall have the right to appear at the hearing.

g. The hearing shall be heard by a department of inspections and appeals designee pursuant to Iowa Code chapter 17A. (The hearing shall be public unless the resident or representative requests in writing that it be closed.) The licensee or designee shall have the opportunity to present to the representative of the department any oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and responsible party shall also have an opportunity to present to the representative of the department any oral testimony or written material to show just cause why a transfer or discharge should not be made. In a determination as to whether a transfer or discharge is authorized, the burden of proof rests on the party requesting the transfer or discharge.

h. Based upon all testimony and materials submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and

conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by certified mail to the licensee, resident, responsible party, and department on aging long-term care ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision.

i. A copy of the notice required by paragraph “c” shall be personally delivered to the resident and a copy placed in the resident’s record. A copy shall also be transmitted to the department, the resident’s responsible party, physician, the person or agency responsible for the resident’s placement, maintenance, and care in the facility, and the department on aging long-term care ombudsman.

j. If the basis for an involuntary transfer or discharge is the result of a negative action by the Iowa department of human services or the professional standards review organization (Iowa Foundation for Medical Care), appeals shall be filed with those agencies as appropriate. Continued payment shall be consistent with rules of those agencies.

k. If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

l. The involuntary transfer or discharge shall be discussed with the resident, the resident’s responsible party, and the person or agency responsible for the resident’s placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator’s designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made part of the resident’s record. (II)

m. The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident’s record. (II)

(1) Counseling shall be provided by a qualified individual who meets one of the following criteria:

1. Has a bachelor’s or master’s degree in social work from an accredited college. (II)

2. Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with a public or private agency. (II)

3. Has been employed in a social work capacity for a minimum of four years in a public or private agency. (II)

4. Is a licensed psychologist or psychiatrist. (II)

5. Is any other person of the resident’s choice. (II)

(2) The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be transferred or discharged. (II)

(3) The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

n. In the case of an emergency transfer or discharge as outlined in 58.40(1)“c”(1), the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident’s file and it must contain all the information required by 58.40(1)“d”(1) and (2). In addition, the notice must contain a statement in not less than 12-point type (elite), which reads: “You have a right to appeal the facility’s decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals within 7 days after receiving this notice. If you request a hearing, it will be held no later than 14 days after receipt of your

request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.” A hearing requested pursuant to this subrule shall be held in accordance with paragraphs “f,” “g,” and “h.” (II)

o. Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility’s license by the department of inspections and appeals. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

58.40(2) Intrafacility transfer:

a. Residents shall not be relocated from room to room within a licensed health care facility arbitrarily. (I, II) Involuntary relocation may occur only in the following situations and such situation shall be documented in the resident’s record.

- (1) Incompatibility with or disturbing to other roommates, as documented in the resident’s record.
- (2) For the welfare of the resident or other residents of the facility.
- (3) For medical, nursing or psychosocial reasons, as documented in the resident’s record, as judged by the attending physician, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.
- (4) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex.
- (5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

b. Unreasonable and unjustified reasons for changing a resident’s room without the concurrence of the resident, or responsible party include:

- (1) Change from private pay status to Title XIX, except as outlined in 58.40(2) “a”(5). (II)
- (2) As punishment or behavior modification, except as specified in 58.40(2) “a”(1). (II)
- (3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph “a,” the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. The notification shall be documented in the resident’s record and signed by the resident or responsible party. (II)

d. If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately or as soon as possible of the condition requiring emergency relocation and such notification shall be documented. (II)

481—58.41(135C) Residents’ rights. Each resident shall be encouraged and assisted throughout the resident’s period of stay, to exercise rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident’s choice, free from interference, coercion, discrimination, or reprisal. (II)

58.41(1) The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

58.41(2) The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

- a.* Designation of an employee responsible for handling grievances and recommendations. (II)
- b.* A method of investigating and assessing the validity of a grievance or recommendation. (II)

c. Methods of resolving grievances. (II)

d. Methods of recording grievances and actions taken. (II)

58.41(3) The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, and resident advocate committee members and the text of Iowa Code section 135C.46 to provide to residents a further course of redress. (II)

481—58.42(135C) Financial affairs—management. Each resident who has not been assigned a guardian or conservator by the court may manage the resident's own personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

58.42(1) The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

58.42(2) An employee shall be designated in writing to be responsible for resident accounts. (II)

58.42(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or mentally retarded resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

58.42(4) If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge that the resident has seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

58.42(5) A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

58.42(6) A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of a mentally retarded individual when ordered in writing by a physician and authorized by a designated qualified mental retardation professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

58.43(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

58.43(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

58.43(3) Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff. (II)

58.43(4) Physicians' orders are required to utilize all types of physical restraints and shall be renewed at least quarterly. (II) Physical restraints are defined as the following:

Type I—the equipment used to promote the safety of the individual but is not applied directly to their person. Examples: divided doors and totally enclosed cribs.

Type II—the application of a device to the body to promote safety of the individual. Examples: vest devices, soft-tie devices, hand socks, geriatric chairs.

Type III—the application of a device to any part of the body which will inhibit the movement of that part of the body only. Examples: wrist, ankle or leg restraints and waist straps.

58.43(5) Physical restraints are not to be used to limit resident mobility for the convenience of staff and must comply with life safety requirements. If a resident's behavior is such that it may result in injury to the resident or others and any form of physical restraint is utilized, it should be in conjunction with a treatment procedure(s) designed to modify the behavioral problems for which the resident is restrained, or as a last resort, after failure of attempted therapy. (I, II)

58.43(6) Each time a Type II or III restraint is used documentation on the nurse's progress record shall be made which includes type of restraint and reasons for the restraint and length of time resident was restrained. The documentation of the use of Type III restraint shall also include the time of position change. (II)

58.43(7) Each facility shall implement written policies and procedures governing the use of restraints which clearly delineate at least the following:

- a.* Physicians' orders shall indicate the specific reasons for the use of restraints. (II)
- b.* Their use is temporary and the resident will not be restrained for an indefinite amount of time. (I, II)
- c.* A qualified nurse shall make the decision for the use of a Type II or Type III restraint for which there shall be a physician's order. (II)
- d.* A resident placed in a Type II or III restraint shall be checked at least every 30 minutes by appropriately trained staff. No form of restraint shall be used or applied in such a manner as to cause injury or the potential for injury and provide a minimum of discomfort to resident restrained. (I, II)
- e.* Reorders are issued only after the attending physician reviews the resident's condition. (II)
- f.* Their use is not employed as punishment, for the convenience of the staff, or as a substitute for supervision or program. (I, II)
- g.* The opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which Type II and Type III restraints are employed, except when resident is sleeping. However, when resident awakens, this shall be provided. This shall be documented each time. A check sheet may serve this purpose. (I, II)
- h.* Locked restraints or leather restraints shall not be permitted except in life-threatening situations. Straight jackets and secluding residents behind locked doors shall not be employed. (I, II)
- i.* Nursing assessment of the resident's need for continued application of a Type III restraint shall be made every 12 hours and documented on the nurse's progress record. Documentation shall include the type of restraint, reason for the restraint and the circumstances. Nursing assessment of the resident's need for continued application of either a Type I or Type II restraint and nursing evaluation of the resident's physical and mental condition shall be made every 30 days and documented on the nurse's progress record. (II)
- j.* A divided door equipped with a securing device that may be readily opened by personnel shall be considered an appropriate means of temporarily confining a resident in the resident's room. (II)
- k.* Divided doors shall be of the type that when the upper half is closed the lower section shall close. (II)
- l.* Methods of restraint shall permit rapid removal of the resident in the event of fire or other emergency. (I, II)
- m.* The facility shall provide orientation and ongoing education programs in the proper use of restraints.

58.43(8) In the case of a mentally retarded individual who participates in a behavior modification program involving use of restraints or aversive stimuli, the program shall be conducted only with the informed consent of the individual's parent or responsible party. Where restraints are employed, an individualized program shall be developed by the interdisciplinary team with specific methodologies for monitoring its progress. (II)

a. The resident's responsible party shall receive a written account of the proposed plan of the use of restraints or aversive stimuli and have an opportunity to discuss the proposal with a representative(s) of the treatment team. (II)

b. The responsible party must consent in writing prior to the use of the procedure. Consent may also be withdrawn in writing. (II)

58.43(9) Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain that separation until the abuse investigation is completed. (I, II)

58.43(10) Suspected abuse reports. The department shall investigate all complaints of dependent adult abuse which are alleged to have happened in a health care facility. The department shall inform the department of human services of the results of all evaluations and dispositions of dependent adult abuse investigations.

58.43(11) Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

This rule is intended to implement Iowa Code sections 135C.14, 235B.3(1), and 235B.3(11).

481—58.44(135C) Resident records. Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

58.44(1) The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

58.44(2) Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

58.44(3) The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

481—58.45(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (II)

58.45(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

58.45(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

58.45(3) Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

58.45(4) Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

58.45(5) Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply in emergency conditions. (II)

481—58.46(135C) Resident work. No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. (II)

58.46(1) Residents may not be used to provide a source of labor for the facility against their will. Physician's approval is required for all work programs. (I, II)

58.46(2) If the plan of care requires activities for therapeutic or training reasons, the plan for these activities shall be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time limited and reviewed at least quarterly. (II)

58.46(3) Residents who perform work for the facility must receive remuneration unless the work is part of their approved training program. Persons on the resident census performing work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

481—58.47(135C) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

58.47(1) Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

58.47(2) Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- a. The resident refuses to see the visitor(s). (II)
- b. The resident's physician documents specific reasons why such a visit would be harmful to the resident's health. (II)
- c. The visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

58.47(3) Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician; at least quarterly by the facility's staff; or at the resident's request. (II)

58.47(4) Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

58.47(5) Telephones consistent with ANSI standards (405.1134(c)) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

58.47(6) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

58.47(7) Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified mental retardation professional or facility administrator for refusing permission. (II)

58.47(8) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

481—58.48(135C) Resident activities. Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the attending physician or qualified mental retardation professional as appropriate in the resident's record. (II)

58.48(1) Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

58.48(2) All residents shall have the freedom to refuse to participate in these activities. (II)

481—58.49(135C) Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

58.49(1) Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

58.49(2) Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

58.49(3) Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart. The facility shall be responsible for secure storage of the items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

58.49(4) A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

58.49(5) A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

481—58.50(135C) Family visits. Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room if available. (II)

58.50(1) The facility shall provide for needed privacy in visits between spouses. (II)

58.50(2) Spouses who are residents in the same facility shall be permitted to share a room, if available, unless one of their attending physicians documents in the medical record those specific reasons why an arrangement would have an adverse effect on the health of the resident. (II)

58.50(3) Family members shall be permitted to share a room, if available, if requested by both parties, unless one of their attending physicians documents in the medical record those specific reasons why such an agreement would have an adverse effect on the health of the resident. (II)

481—58.51(135C) Choice of physician and pharmacy. Each resident shall be permitted free choice of a physician and a pharmacy, if accessible. The facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility.

A facility shall not require the repackaging of medications dispensed by the Veterans Administration or an institution operated by the Veterans Administration for the purpose of making the drug distribution system compatible with the system used by the facility. (II)

481—58.52(135C) Incompetent resident.

58.52(1) Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

58.52(2) The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

481—58.53(135C) County care facilities. In addition to Chapter 58 licensing rules, county care facilities licensed as nursing facilities must also comply with department of human services rules, 441—Chapter 37. Violation of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

481—58.54(73GA,ch 1016) Special unit or facility dedicated to the care of persons with chronic confusion or a dementing illness (CCDI unit or facility).

58.54(1) A nursing facility which chooses to care for residents in a distinct part shall obtain a license for a CCDI unit or facility. In the case of a distinct part, this license will be in addition to its ICF license. The license shall state the number of beds in the unit or facility. (III)

a. Application for this category of care shall be submitted on a form provided by the department. (III)

b. Plans to modify the physical environment shall be submitted to the department. The plans shall be reviewed based on the requirements of 481—Chapter 61. (III)

58.54(2) A statement of philosophy shall be developed for each unit or facility which states the beliefs upon which decisions will be made regarding the CCDI unit or facility. Objectives shall be developed for each CCDI unit or facility as a whole. The objectives shall be stated in terms of expected results. (II, III)

58.54(3) A résumé of the program of care shall be submitted to the department for approval at least 60 days before a separate CCDI unit or facility is opened. A new résumé of the program of care shall be submitted when services are substantially changed. (II, III)

The résumé of the program of care shall:

a. Describe the population to be served; (II, III)

b. State philosophy and objectives; (II, III)

c. List admission and discharge criteria; (II, III)

d. Include a copy of the floor plan; (II, III)

e. List the titles of policies and procedures developed for the unit or facility; (II, III)

f. Propose a staffing pattern; (II, III)

g. Set out a plan for specialized staff training; (II, III)

h. State visitor, volunteer, and safety policies; (II, III)

i. Describe programs for activities, social services and families; (II, III) and

j. Describe the interdisciplinary care planning team. (II, III)

58.54(4) Separate written policies and procedures shall be implemented in each CCDI unit or facility. There shall be:

a. Admission and discharge policies and procedures which state the criteria to be used to admit residents and the evaluation process which will be used. These policies shall require a statement from the attending physician agreeing to the placement before a resident can be moved into a CCDI unit or facility. (II, III)

b. Safety policies and procedures which state the actions to be taken by staff in the event of a fire, natural disaster, emergency medical or catastrophic event. Safety procedures shall also explain steps to be taken when a resident is discovered to be missing from the unit or facility and when hazardous cleaning materials or potentially dangerous mechanical equipment is being used in the unit or facility. The facility shall identify its method for security of the unit or facility and the manner in which the effectiveness of the security system will be monitored. (II, III)

c. Program and service policies and procedures which explain programs and services offered in the unit or facility including the rationale. (III)

d. Policies and procedures concerning staff which state minimum numbers, types and qualifications of staff in the unit or facility. (II, III)

e. Policies about visiting which suggest times and ensure the residents' rights to free access to visitors. (II, III)

f. Quality assurance policies and procedures which list the process and criteria which will be used to monitor and to respond to risks specific to the residents. This shall include, but not be limited to, drug use, restraint use, infections, incidents and acute behavioral events. (II, III)

58.54(5) Preadmission assessment of physical, mental, social and behavioral status shall be completed to determine whether the applicant meets admission criteria. This assessment shall be completed by a registered nurse and a staff social worker or social work consultant and shall become part of the permanent record upon admission of the resident. (II, III)

58.54(6) All staff working in a CCDI unit or facility shall have training appropriate to the needs of the residents. (II, III)

a. Upon assignment to the unit or facility, everyone working in the unit or facility shall be oriented to the needs of people with chronic confusion or dementing illnesses. They shall have special training appropriate to their job description within 30 days of assignment to the unit or facility. (II, III) The orientation shall be at least six hours. The following topics shall be covered:

- (1) Explanation of the disease or disorder; (II, III)
- (2) Symptoms and behaviors of memory-impaired people; (II, III)
- (3) Progression of the disease; (II, III)
- (4) Communication with CCDI residents; (II, III)
- (5) Adjustment to care facility residency by the CCDI unit or facility residents and their families; (II, III)
- (6) Inappropriate and problem behavior of CCDI unit or facility residents and how to deal with it; (II, III)
- (7) Activities of daily living for CCDI residents; (II, III)
- (8) Handling combative behavior; (II, III) and
- (9) Stress reduction for staff and residents. (II, III)

b. Licensed nurses, certified aides, certified medication aides, social services personnel, housekeeping and activity personnel shall have a minimum of six hours of in-service training annually. This training shall be related to the needs of CCDI residents. The six-hour training shall count toward the required annual in-service training. (II, III)

58.54(7) There shall be at least one nursing staff person on a CCDI unit at all times. (I, II, III)

58.54(8) The CCDI unit or facility license may be revoked, suspended or denied pursuant to Iowa Code chapter 135C and Iowa Administrative Code 481—Chapter 50.

This rule is intended to implement 1990 Iowa Acts, chapter 1016.

481—58.55(135C) Another business or activity in a facility. A facility is allowed to have another business or activity in a health care facility or in the physical structure of the facility, if the other business or activity meets the requirements of applicable state and federal laws, administrative rules, and federal regulations.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs “a” through “f” of subrule 58.55(1). (I, II, III)

58.55(1) The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a.* Health and safety risks for residents;
- b.* Noise created by the proposed business or activity;
- c.* Odors created by the proposed business or activity;
- d.* Use of the facility’s corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- e.* Proposed staffing for the business or activity; and
- f.* Sharing of services and staff between the proposed business or activity and the facility.

58.55(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

58.55(3) A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 61. (I, II, III)

481—58.56(135C) Respite care services. Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A nursing facility which chooses to

provide respite care services must meet the following requirements related to respite services and must be licensed as a nursing facility.

58.56(1) A nursing facility certified as a Medicaid nursing facility or Medicare skilled nursing facility must meet all Medicaid and Medicare requirements including CFR 483.12, admission, transfer and discharge rights.

58.56(2) A nursing facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

58.56(3) Rule 481—58.40(135C) regarding involuntary discharge or transfer rights, does not apply to residents who are being cared for under a respite care contract.

58.56(4) Pursuant to rule 481—58.13(135C), the facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements under 481—58.13(135C), except the requirements under subrule 58.13(7).

58.56(5) Respite care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

481—58.57(135C) Training of inspectors.

58.57(1) Subject to the availability of funding, all nursing facility inspectors shall receive 12 hours of annual continuing education in gerontology, wound care, dementia, falls, or a combination of these subjects.

58.57(2) An inspector shall not be personally liable for financing the training required under subrule 58.57(1).

58.57(3) The department shall consult with the collective bargaining representative of the inspector in regard to the training required under this rule.

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.6(1), 135C.14, 135C.25, 135C.32, 135C.36 and 227.4 and 1990 Iowa Acts, chapter 1016.

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[◇] Two or more ARCs

¹ Effective date of 470—58.15(2)“c” delayed 70 days by the Administrative Rules Review Committee, IAB 2/26/86.
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² See IAB, Inspections and Appeals Department.

CHAPTER 59
TUBERCULOSIS (TB) SCREENING

481—59.1(135B,135C) Purpose. The intent of this chapter is to outline requirements and procedures to conduct tuberculosis screening for health care workers in health care facilities and hospitals and for residents of health care facilities regulated by the department.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

481—59.2(135B,135C) Definitions. For purposes of this chapter, the following definitions apply:

“*Bacille Calmette-Guérin (BCG) vaccination*” means a vaccine for TB. BCG is used in many countries with a high prevalence of TB to prevent childhood tuberculosis meningitis and military disease. BCG is not generally recommended for use in the United States because of the low risk of infection with *Mycobacterium tuberculosis*, the variable effectiveness of the vaccine against adult pulmonary TB, and the vaccine’s potential interference with tuberculin skin test reactivity.

“*Baseline TB screening*” means the screening of health care workers (HCWs) of health care facilities or hospitals and residents of health care facilities for latent tuberculosis infection (LTBI) and TB disease at the beginning of employment in a facility or hospital, or upon admission to a facility. Baseline TB screening includes a symptom screen for all HCWs and residents, and tuberculin skin tests (TSTs) or interferon-gamma release assay (IGRA) for *Mycobacterium tuberculosis* for those persons with previous negative test results for *M. tuberculosis* infection.

“*Baseline TST*” or “*baseline IGRA*” means the TST or IGRA, respectively, that is administered at the beginning of employment to newly hired HCWs or upon admission to residents of health care facilities.

“*Boosting*” means a phenomenon in which a person has a negative TST (i.e., false-negative) result years after infection with *M. tuberculosis* and then a positive subsequent TST result. The positive TST result is caused by a boosted immune response of previous sensitivity rather than by a new infection (false-positive TST conversion). Two-step testing reduces the likelihood of mistaking a boosted reaction for a new infection.

“*Department*” means the department of inspections and appeals.

“*Employment*” or “*employed*” means hired or retained for paid or unpaid work in a facility or hospital.

“*Extrapulmonary TB*” means TB disease in any part of the body other than the lungs (e.g., kidney, spine, or lymph nodes).

“*Health care facility*” or “*facility*” means a health care facility as defined in Iowa Code section 135C.1 or a long-term care service of a hospital as defined in rule 481—51.38(135B).

“*Health care worker*” or “*HCW*” means any paid or unpaid person working in a health care facility or hospital, including any person who is paid either by the health care facility or hospital, or paid by any other entity (i.e., temporary agency, private duty, Medicaid/Medicare or independent contractors), or any volunteer who volunteers in a health care facility or hospital on a consistent and regularly scheduled basis for five or more hours per week. Specifically excluded from the definition of “health care worker” are individuals such as visitors, building contractors, repair workers or others who are in the facility or hospital for a very limited purpose and are not in the facility or hospital on a regular basis.

“*Hospital*” means a hospital as defined in Iowa Code section 135B.1.

“*Interferon-gamma release assay*” or “*IGRA*” means whole-blood tests that can aid in diagnosing *Mycobacterium tuberculosis* infection.

“*Laryngeal TB*” means a form of TB disease that involves the larynx and may be highly infectious.

“*Latent TB infection*” or “*LTBI*” means infection with *M. tuberculosis* without symptoms or signs of disease having manifested.

“*Mantoux method*” means a skin test performed by intradermally injecting 0.1 mL of purified protein derivative (PPD) tuberculin solution into the volar or dorsal surface of the forearm.

“*Patient*” means a person admitted to a hospital.

“*Pulmonary TB*” means TB disease that occurs in the lung parenchyma, usually producing a cough that lasts greater than three weeks. Pulmonary TB is usually infectious.

“*Purified protein derivative (PPD) tuberculin*” means a material used in diagnostic tests for detecting infection with *M. tuberculosis*.

“*Resident*” means a person admitted to a health care facility or a long-term care service of a hospital as defined in rule 481—51.38(135B). For purposes of this chapter, “resident” does not include a patient admitted to a hospital.

“*Risk classification*” means the category the infection control team, or designated other staff, determines is appropriate for the facility or hospital as a result of the TB risk assessment.

“*Serial screening*” refers to TB screening performed at regular intervals following baseline TB screening. Serial TB screening, also called annual or ongoing TB testing, consists of two components: (1) assessing for current symptoms of active TB disease, and (2) testing for the presence of infection with *M. tuberculosis* by administering either a TST or single IGRA.

“*Symptom screen*” means a procedure used during a clinical evaluation in which persons are asked if they have experienced any departure from normal in function, appearance, or sensation related to TB disease (e.g., cough).

“*TB patient*” means a person who had undiagnosed infectious pulmonary or laryngeal TB while in a health care facility or hospital during the preceding year. “TB patient” does not include persons with LTBI (treated or untreated), extrapulmonary TB disease, pulmonary, or laryngeal TB that have met criteria for noninfectiousness.

“*TB risk assessment*” means an initial and ongoing evaluation of the risk for transmission of *M. tuberculosis* in a particular health care setting.

“*TB screening*” means an administrative control measure in which evaluation for LTBI and TB disease is performed through baseline and serial screening of HCWs in hospitals and health care facilities and residents of health care facilities.

“*TB screening plan*” means a plan that health care facilities and hospitals develop and implement that comprises four major components: (1) baseline testing for *M. tuberculosis* infection, (2) serial testing for *M. tuberculosis* infection, (3) serial screening for signs or symptoms of TB disease, and (4) TB training and education.

“*Treatment for LTBI*” means treatment that prevents the progression of *M. tuberculosis* infection into TB disease.

“*Tuberculin skin test*” or “*TST*” means a diagnostic aid for finding *M. tuberculosis* infection. The Mantoux method is the recommended method to be used for TST.

“*Tuberculosis*” or “*TB*” means the namesake member organism of *M. tuberculosis* complex and the most common causative infectious agent of TB disease in humans. In certain instances, the species name refers to the entire *M. tuberculosis* complex, which includes *M. bovis* and *M. african*, *M. microti*, *M. canetti*, *M. caprae*, and *M. pinnipedii*.

“*Tuberculosis disease*” or “*TB disease*” means a condition caused by infection with a member of the *M. tuberculosis* complex that has progressed to causing clinical (manifesting symptoms or signs) or subclinical (early stage of disease in which signs or symptoms are not present, but other indications of disease activity are present) illness.

“*Two-step tuberculin skin test*” or “*two-step TST*” means the procedure used for the baseline skin testing of persons who will receive serial TSTs to reduce the likelihood of mistaking a boosted reaction for a new infection.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter; ARC 0674C, IAB 4/3/13, effective 3/26/13]

481—59.3(135B,135C) TB risk assessment.

59.3(1) Annually, a health care facility or hospital shall conduct a TB risk assessment to evaluate the risk for transmission of *M. tuberculosis*, regardless of whether a person with suspected or confirmed TB disease is expected to be encountered in the facility or hospital. The TB risk assessment shall be utilized to determine the types of administrative, environmental, and respiratory protection controls needed and

serves as an ongoing evaluation tool of the quality of TB infection control and for the identification of needed improvements in infection control measures.

59.3(2) The TB risk assessment shall include:

- a. The community rate of TB,
- b. The number of persons with infectious TB encountered in the facility or hospital, and
- c. The speed with which persons with infectious TB disease are suspected, isolated, and evaluated to determine if persons with infectious TB exposed staff or others in the facility or hospital. TB cases include persons who had undiagnosed infectious pulmonary or laryngeal TB while in the facility or hospital during the preceding year. This does not include persons with LTBI (treated or untreated), persons with extrapulmonary TB disease, or persons with pulmonary and laryngeal TB that have met criteria for noninfectiousness.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

481—59.4(135B,135C) Health care facility or hospital risk classification. The infection control team or designated staff in a health care facility or hospital is responsible for determining the type of risk classification. The facility or hospital risk classification is used to determine frequency of TB screening. The facility or hospital risk classification may change due to an increase or decrease in the number of TB cases during the preceding year. The following criteria are consistent with those of the Centers for Disease Control and Prevention (CDC), TB Elimination Division, as outlined in the MMWR December 30, 2005/Vol.54/No.RR-17, “Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005.”

59.4(1) *Types of risk classifications.*

- a. “Low risk” means that a facility or hospital is one in which persons with active TB disease are not expected to be encountered and in which exposure to TB is unlikely.
- b. “Medium risk” means that a facility or hospital is one in which health care workers will or might be exposed to persons with active TB disease or to clinical specimens that might contain *M. tuberculosis*.
- c. “Potential ongoing transmission” means that a facility or hospital is one in which there is evidence of person-to-person transmission of *M. tuberculosis*. This classification is a temporary classification. If it is determined that this classification applies to a facility or hospital, the facility or hospital shall consult with the department of public health’s TB control program.

59.4(2) *Classification criteria—low risk.*

- a. Inpatient settings with 200 beds or more: If a facility or hospital has fewer than six TB patients for the preceding year, the facility or hospital shall be classified as low risk.
- b. Inpatient settings with fewer than 200 beds: If a facility or hospital has fewer than three TB patients for the preceding year, the facility or hospital shall be classified as low risk.

59.4(3) *Classification criteria—medium risk.*

- a. Inpatient settings with 200 beds or more: If a facility or hospital has six or more TB patients for the preceding year, the facility or hospital shall be classified as medium risk.
- b. Inpatient settings with fewer than 200 beds: If a facility or hospital has three or more TB patients for the preceding year, the facility or hospital shall be classified as medium risk.

59.4(4) *Classification criteria—potential ongoing transmission.* If evidence of ongoing *M. tuberculosis* transmission exists at a facility or hospital, the facility or hospital shall be classified as potential ongoing transmission, regardless of the facility’s or hospital’s previous classification.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

481—59.5(135B,135C) Baseline TB screening procedures for health care facilities and hospitals.

59.5(1) All HCWs shall receive baseline TB screening upon hire. Baseline TB screening consists of two components: (1) assessing for current symptoms of active TB disease and (2) using a two-step TST or a single IGRA to test for infection with *M. tuberculosis*.

59.5(2) An HCW may begin working with patients or residents after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative TST (i.e., first step) or negative IGRA. The second TST may be performed after the HCW starts working with patients or residents.

59.5(3) An HCW with a new positive test result for *M. tuberculosis* infection (i.e., TST or IGRA) shall receive one chest radiograph result to exclude TB disease. Repeat radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a clinician. Treatment for LTBI should be considered in accordance with CDC guidelines.

59.5(4) An HCW with documentation of past positive test results (i.e., TST or IGRA) and documentation of the results of a chest radiograph indicating no active disease, dated after the date of the positive TST or IGRA test result, does not need another chest radiograph at the time of hire.

59.5(5) TB, TST or IGRA tests for *M. tuberculosis* infection do not need to be performed for HCWs with a documented history of TB disease, documented previously positive test result for *M. tuberculosis* infection, or documented completion of treatment for LTBI or TB disease. Documentation of a previously positive test result for *M. tuberculosis* infection can be substituted for a baseline test result if the documentation includes a recorded TST result in millimeters or IGRA result, including the concentration of cytokine measured (e.g., interferon-gamma (IFN-g)). All other HCWs should undergo baseline testing for *M. tuberculosis* infection to ensure that the test result on record in the setting has been performed and measured using the recommended diagnostic procedures.

59.5(6) A second TST is not needed if the HCW has a documented TST result from any time during the previous 12 months. If a newly employed HCW has had a documented negative TST result within the previous 12 months, a single TST can be administered in the new setting. This additional TST represents the second stage of two-step testing. The second test decreases the possibility that boosting on later testing will lead to incorrect suspicion of transmission of *M. tuberculosis* in the setting.

59.5(7) Previous BCG vaccination is not a contraindication to having an IGRA, a TST or two-step skin testing administered. HCWs with previous BCG vaccination should receive baseline and serial testing in the same manner as those without BCG vaccination. Evaluation of TST reactions in persons vaccinated with BCG should be interpreted using the same criteria for those not BCG-vaccinated. An HCW's history of BCG vaccination should be disregarded when administering and interpreting TST results. Prior BCG vaccination does not cause a false-positive IGRA test result.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

481—59.6(135B,135C) Serial TB screening procedures for health care facilities and hospitals.

59.6(1) *Health care facilities or hospitals classified as low risk.* After baseline testing of HCWs for infection with *M. tuberculosis*, additional TB screening of HCWs is not necessary unless an exposure to *M. tuberculosis* occurs.

59.6(2) *Health care facilities or hospitals classified as medium risk.*

a. After undergoing baseline testing for infection with *M. tuberculosis*, HCWs should receive TB screening annually (i.e., symptom screen for all HCWs and testing for infection with *M. tuberculosis* for HCWs with baseline negative test results).

b. HCWs with a baseline positive or new positive test result for *M. tuberculosis* infection or documentation of previous treatment for LTBI or TB disease shall receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, HCWs should receive a symptom screen annually. This screen should be accomplished by educating HCWs about symptoms of TB disease and instructing HCWs to report any such symptoms immediately to the occupational health unit. Treatment for LTBI should be considered in accordance with CDC guidelines.

59.6(3) *Health care facilities or hospitals classified as potential ongoing transmission.* Testing for infection with *M. tuberculosis* may need to be performed every eight to ten weeks until lapses in infection control have been corrected and no additional evidence of ongoing transmission is apparent. The potential ongoing transmission classification should be used only as a temporary classification. This classification warrants immediate investigation and corrective steps. After a determination that ongoing transmission has ceased, the setting shall be reclassified as medium risk for a minimum of one year.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

481—59.7(135B,135C) Screening of HCWs who transfer to other health care facilities or hospitals.

59.7(1) *HCWs transferring from a low-risk health care facility or hospital to another low-risk health care facility or hospital.* After a baseline result for infection with *M. tuberculosis* is established and

documented, serial testing for *M. tuberculosis* infection is not necessary for HCWs transferring from a low-risk health care facility or hospital to another low-risk health care facility or hospital.

59.7(2) *HCWs transferring from a low-risk health care facility or hospital to a medium-risk health care facility or hospital.* After a baseline result for infection with *M. tuberculosis* is established and documented, annual TB screening, including a symptom screen and TST or IGRA for persons with previously negative test results, should be performed for HCWs transferring from a low-risk health care facility or hospital to a medium-risk health care facility or hospital.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

481—59.8(135B,135C) Baseline TB screening procedures for residents of health care facilities.

59.8(1) TB screening is a formal procedure to evaluate residents for LTBI and TB disease. Baseline TB screening consists of two components: (1) assessing for current symptoms of active TB disease and (2) using two-step TST or a single IGRA to test for infection with *M. tuberculosis*.

59.8(2) All residents shall be assessed for current symptoms of active TB disease upon admission. Within 72 hours of a resident's admission, baseline TB testing for infection shall be initiated unless baseline TB testing occurred within three months prior to the resident's admission.

59.8(3) Residents with a new positive test result for *M. tuberculosis* infection (i.e., TST or IGRA) shall receive one chest radiograph result to exclude TB disease. Repeat radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a clinician.

59.8(4) Residents with documentation of past positive test results (i.e., TST or IGRA) and documentation of the results of a chest radiograph indicating no active disease, dated after the date of the positive TST or IGRA test result, do not need another chest radiograph at the time of admission.

59.8(5) TB, TST or IGRA tests for *M. tuberculosis* infection do not need to be performed for residents with a documented history of TB disease, documented previously positive test result for *M. tuberculosis* infection, or documented completion of treatment for LTBI or TB disease. Documentation of a previously positive test result for *M. tuberculosis* infection can be substituted for a baseline test result if the documentation includes a recorded TST result in millimeters or IGRA result, including the concentration of cytokine measured (e.g., IFN-g). All other residents should undergo baseline testing for *M. tuberculosis* infection to ensure that the test result on record in the setting has been performed and measured using the recommended diagnostic procedures.

59.8(6) A second TST is not needed if the resident has a documented TST result from any time during the previous 12 months. If a new resident has had a documented negative TST result within the previous 12 months, a single TST can be administered in the new setting. This additional TST represents the second stage of two-step testing. The second test decreases the possibility that boosting on later testing will lead to incorrect suspicion of transmission of *M. tuberculosis* in the health care facility.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

481—59.9(135B,135C) Serial TB screening procedures for residents of health care facilities. After baseline TB screening is accomplished, serial TB screening of residents is not recommended.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

481—59.10(135B,135C) Performance of screening and testing. Any nurse licensed in Iowa and properly trained to screen for TB and perform TB testing may screen for TB and perform TB testing.

[ARC 0484C, IAB 12/12/12, effective 1/16/13; see Delay note at end of chapter]

These rules are intended to implement Iowa Code sections 135B.7 and 135C.14.

[Filed ARC 0484C (Notice ARC 0353C, IAB 10/3/12), IAB 12/12/12, effective 1/16/13]¹

[Filed Emergency ARC 0674C, IAB 4/3/13, effective 3/26/13]

¹ January 16, 2013, effective date of Chapter 59 [ARC 0484C] delayed 70 days by the Administrative Rules Review Committee at its meeting held January 8, 2013.

CHAPTER 62
RESIDENTIAL CARE FACILITIES
FOR PERSONS WITH MENTAL ILLNESS (RCF/PMI)

481—62.1(135C) Definitions. For the purposes of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered incorporated verbatim in the rules. The use of the words “shall” and “must” indicate these standards are mandatory.

“*Abuse*” means any of the following as a result of the willful or negligent acts or omissions of a caretaker:

1. Physical abuse
2. Physical injury to or unreasonable confinement or cruel punishment of a resident
3. Sexual abuse
4. Mental abuse
5. Verbal abuse
6. Exploitation of a resident
7. The deprivation of the minimum food, shelter, clothing, supervision, physical and mental health care, and other care necessary to maintain a resident’s life or health as a result of the acts or omissions of the resident.

“*Academic services*” means those activities provided to assist a person to acquire general information and skills which establish the basis for subsequent acquisition and application of knowledge.

“*Age appropriate*” means those activities, settings, and personal appearance and possessions commensurate with the person’s chronological age.

“*Chronic mental illness*” means a persistent mental or emotional disorder that seriously impairs an adult’s functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.

“*Commission*” means the mental health and mental retardation commission.

“*Community living training services*” are those activities provided to assist a person to acquire or sustain the knowledge and skills essential to independent functioning to the person’s maximum potential in the physical and social environment. These services may focus on the following areas:

1. Independent living skills means those skills necessary to sustain oneself in the physical environment and are essential to the management of one’s personal property and business. This includes self-advocacy skills.
2. Socialization skills which include self-awareness and self-control, social responsiveness, group participation, social amenities, and interpersonal skills.
3. Communication skills which include expressive and receptive skills in verbal and nonverbal language including reading and writing.
4. Leisure time and recreational skills which include the skills necessary for a person to use leisure time in a manner which is satisfying and constructive to the person.
5. Parenting skills which include those skills necessary to meet the needs of the person’s child. This service is designed to assist the person with mental illness to acquire or sustain the skills necessary for parenting.

“*Department*” means the Iowa department of inspections and appeals.

“*Diagnosis*” means the investigation and analysis of the cause or nature of a person’s condition, situation, or problem.

“*Direct care staff*” means those staff persons who provide a homelike environment for the residents and assist or supervise the resident in meeting the goals in the resident’s program plan.

“*Evaluation services*” means those activities designed to identify a person’s current functioning level and those factors which are barriers to maintaining the current level or achieving a higher level of functioning.

“Exploitation” means the act or process of taking unfair advantage of a resident, or the resident’s physical or financial resources, for one’s own personal or pecuniary profit by the use of undue influence, harassment, duress, deception, false representation, or false pretenses.

“Goals” means general statements of attainable expected accomplishments to be achieved in meeting identified needs.

“Incident” means all accidental, purposeful, or other occurrences within the facility or on the premises affecting residents, visitors, or employees whether there is apparent injury or where hidden injury may have occurred.

“Individual program plan (IPP)” means a written plan for the provision of services to the resident that is developed and implemented using an interdisciplinary process, that is based on the resident’s functional status, strengths and needs, and that identifies service activities designed to enable a person to maintain or move toward independent functioning. The plan identifies a continuum of development and outlines progressive steps and anticipated outcomes of services.

“Informed consent” means an agreement by a person, or by the person’s legally authorized representative, based upon an understanding of:

1. A full explanation of the procedures to be followed including an identification of those that are and are not experimental,
2. A description of the attendant discomforts, risks, and benefits to be expected,
3. A disclosure of appropriate alternative procedures that would be advantageous for the person.

“Interdisciplinary process” means an approach to assessment, individual program planning, and service implementation in which planning participants function as a team. Each participant utilizing the skills, competencies, insights and perspectives provided by the participant’s training and experience focuses on identifying the service needs of the resident and the resident’s family. The purpose of the process is for participants to review and discuss, face-to-face, all information and recommendations and to reach decisions as a team. Participants share all information and recommendations, and develop as a team a single, integrated, individual program plan to meet the resident’s and, when appropriate, the resident’s family’s needs.

“Interdisciplinary team” means the group of persons who develop a single, integrated, individual program plan to meet a resident’s needs for services. The interdisciplinary team consists of, at a minimum, the resident, the resident’s legal guardian, if applicable, the resident’s advocate if desired by the resident, a referral agency representative, other appropriate staff members, other providers of services, and other persons relevant to resident’s needs.

“Least restrictive environment” means the environment in which the interventions in the lives of people with mental illness can be carried out with a minimum of limitation, intrusion, disruption, and departure from commonly accepted patterns of living.

It is the environment which allows residents to participate, to the maximum extent possible, in everyday life and to have control over the decisions that affect them. It is an environment that provides needed supports which do not interfere with personal liberty and do not unduly interfere with a person’s access to the normal events of life.

“Legal services” means those activities designed to assist the person in exercising constitutional and legislatively enacted rights.

“Level of functioning” means a person’s current physiological and psychological status and current academic, community living, self-care, and vocational skills.

“Long-term residential care facility for persons with mental illness (RCF/PMI)” means a residential setting to maintain or improve community living skills to reach maximum potential for independent living and to prevent movement to a more restrictive setting.

“Mechanical restraint” means a device applied to a person’s limbs, head, or body which restricts a person’s movement and includes but is not limited to leather straps, leather cuffs, camisoles, or handcuffs.

“Mental abuse” means, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

“Mental illness” means a substantial disorder of thought or mood which significantly impairs judgment, behavior, or the capacity to recognize reality or the ability to cope with the ordinary demands

of life. Mental disorders include the organic and functional psychoses, neuroses, personality disorders, alcoholism and drug dependence, behavioral disorders and other disorders as defined by the current edition of American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

“Normalization” means helping persons, in accordance with their needs and preference, to achieve a lifestyle that is consistent with the norms and patterns of general society and in ways which incorporate the age-appropriate and least restrictive principles.

“Objectives” means specific, time-limited, and measurable statements showing outcomes or accomplishments necessary to progress toward the goal.

“Physical abuse” means, but is not limited to, corporal punishment and the use of restraints as punishment.

“Physical injury” means damage to any bodily tissue to the extent the tissue must undergo a healing process in order to be restored to a sound and healthy condition. It may also mean damage to the extent the bodily tissue cannot be restored to a sound and healthy condition, or results in the death of the resident whose bodily tissue sustained the damage.

“Physical or physiological treatment” means those activities designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the physical or physiological functioning of the human body.

“Physical restraint” means a technique involving the use of one or more of a staff person’s arms, legs, hands or other body areas to restrict or control the movements of a resident. This does not include the use of mechanical restraint.

“Physician” means a person licensed to practice medicine and surgery, osteopathy and surgery, osteopathy, or chiropractic under the laws of this state; but a physician licensed as a physician and surgeon shall be designated as a “physician” or “surgeon”; a person licensed as an osteopath and surgeon shall be designated as an “osteopathic physician” or “osteopathic surgeon”; a person designated as an osteopath shall be designated as an “osteopathic physician”; and a person licensed as a chiropractor shall be designated as a “chiropractor.”

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for any of the following:

1. Special target populations,
2. The population of a specified geographic area(s),
3. A specified purpose, and
4. A person.

“Psychotherapeutic treatment” means those activities designed to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person’s functioning in response to the physical, emotional and social environment.

“Qualified mental health professional (QMHP)” means a person who:

Is a psychiatrist, psychologist, social worker, psychiatric nurse or mental health counselor; or

Is a doctor of medicine or osteopathic medicine or has at least a master’s degree or its equivalent with coursework focusing on diagnosis and evaluation and psychotherapeutic treatment of mental health problems and mental illness.

Equivalent means at least 32 semester hours of graduate level study in the following areas:

1. Psychology (normal and abnormal)
2. Assessment (psychological and physiological)
3. Growth, development, and personality
4. Learning theory
5. Counseling theory and technique (group dynamics)
6. Human behavior
7. Sociology
8. Interpersonal relations
9. Change
10. Systems theory
11. Interdisciplinary team process

12. Organizational theory

13. Planning

These persons must have two years of documented supervised experience in providing mental health services; or

Is employed by a community mental health center or mental health service provider accredited by the commission and has less than a master's degree but at least a bachelor's degree and sufficient education and experience as determined by the chief administrative officer of the community mental health center, with the approval of the commission with coursework and experience focusing on diagnosis and evaluation and treatment of persons with mental health problems and mental illness.

All persons must hold a current license when required by Iowa law.

1. *"Psychiatrist"* means a doctor of medicine or osteopathic medicine and surgery who is certified by the American Board of Psychiatry and Neurology or who is eligible for certification.

2. *"Psychologist"* means a person who is licensed to practice psychology in the state of Iowa, or is certified by the Iowa department of education as a school psychologist, or is eligible for certification, or meets the requirements for eligibility for a license to practice psychology in the state of Iowa that were effective prior to July 1, 1985.

3. *"Social worker"* means a person who is licensed to practice social work in the state of Iowa, or who is eligible for licensure.

4. *"Psychiatric nurse"* means a person who meets the requirements of certified psychiatric-mental health nurse practitioner pursuant to 655—Chapter 7, Iowa Administrative Code, or is eligible for certification.

5. *"Mental health counselor"* means a person who is certified or eligible for certification as a mental health counselor by the National Academy of Certified Clinical Mental Health Counselors.

"Resident" means a person who has been admitted to the facility to receive care and services.

"Seclusion" means the isolation of the resident in a locked room which cannot be opened by the resident.

"Self-care training services" means those activities provided to assist a person to acquire or sustain the knowledge, habits, and skills essential to the daily needs of the person. The activities focus on personal hygiene, general health maintenance, mobility skills, and other activities of daily living.

"Service" means a set of interrelated activities provided to a resident pursuant to the IPP.

"Sexual abuse" means, but is not limited to, the exposing of pubes to a resident, the exposure of a resident's genitals, pubes, breasts or buttocks for sexual satisfaction, fondling or touching the inner thigh, groin, buttocks, anus or breast of a resident or the clothing covering these areas, sexually suggestive comments or remarks made to a resident, a genital to genital or oral to genital contact or the commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2.

"Short-term transitional residential care facility for persons with mental illness" means a transitional setting to move the person toward independent living by helping the person gain mastery of independent living skills.

"Support services" means those activities provided to or on behalf of a person in the areas of personal care and assistance and property maintenance in order to allow a person to live in the least restrictive environment.

"Transportation services" means those activities designed to assist a person to travel from one place to another to obtain services or carry out life's activities.

"Verbal abuse" means, but is not limited to, the use of derogatory terms or names, undue voice volume and rude comments, orders, or responses to residents.

"Vocational training services" means those activities designed to familiarize a person with production or employment requirements and to maintain or develop the person's ability to function in a work setting. This service includes programming which allows or promotes the development of skills, attitudes, and personal attributes appropriate to the work setting.

"Work" means any activity during which a resident provides goods or services for wages.

"Written, in writing or recorded" means that an account or entry is made in a permanent form.

481—62.2(135C) Application for license.

62.2(1) *Initial application and licensing.* In order to obtain an initial license for a residential care facility for persons with mental illness, the applicant must meet all of the rules, regulations, and standards contained in Iowa Code chapter 135C, and Iowa Administrative Code 481—Chapters 60 and 62, and submit an application to the department which states the type and category of license for which the facility is applying.

- a.* Submit a résumé of care with a narrative which includes the following information:
- (1) The purpose of the facility.
 - (2) A description of the target population and limitations on resident eligibility.
 - (3) An identification and description of the services the facility will provide which shall minimally include specific and measurable goals and objectives for each of the services to be made available by the facility and a description of the resources needed to provide each of the services including staff, physical facilities and funds.
 - (4) A description of the human services system available in the area, including, but not limited to, social, public health, visiting nurse, vocational training, employment services, sheltered living arrangements, and services of private agencies.
 - (5) A description of working relationships with the human services agencies when applicable, which shall include at a minimum:
 1. A description of how the facility will coordinate with the human services to facilitate continuity of care and coordination of services to residents; and
 2. A description of how the facility will coordinate with those agencies to identify unnecessary duplication of services and plan for development and coordination of needed services.
- b.* Submit a floor plan of each floor of the facility drawn on 8½- x 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathroom; and designation of the use to which room will be put and window and door location;
- c.* Submit a photograph of the front and side elevation of the facility;
- d.* Submit the statutory fee for a residential care facility license;
- e.* Show evidence of a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules.

62.2(2) *Renewal application or change of ownership.* In order to obtain a renewal or change of ownership license of the residential care facility to serve persons with mental illness the applicant must:

- a.* Submit to the department the completed application form 30 days prior to annual license renewal or change of ownership date of the residential care facility license.
- b.* Submit the statutory license fee for a residential care facility for persons with mental illness with the application for renewal or change of ownership.
- c.* Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules.
- d.* Submit documentation of review of résumé of care pursuant to 62.2(1) “*a*” and a copy of any revisions to the plan.

This rule is intended to implement Iowa Code sections 135C.7 and 135C.9.

481—62.3(135C) Licenses for distinct parts.

62.3(1) Separate licenses may be issued for distinct parts which are clearly identifiable parts of a health care facility, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

62.3(2) The following requirements shall be met for a separate licensing of a distinct part:

- a.* The distinct part shall serve only residents who require the category of care and services immediately available to them within that part. (III)
- b.* The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought.
- c.* The distinct part must be operationally and financially feasible.

d. A separate personal care staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management. (III)

e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry and dietary in common with each other.

62.3(3) Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

This rule is intended to implement Iowa Code sections 135C.6(1) and 135C.6(2).

481—62.4(135C) Variances. Variances from these rules may be granted by the director of the department:

1. When the need for a variance has been established consistent with the résumé of care or the resident's individual program plan.
2. When there is no danger to the health, safety, welfare, or rights of any resident.
3. The variance will apply only to a specific residential care facility for the mentally ill.
4. Variances shall be reviewed at the time of each licensure survey by the department to see if the need for the variance is still acceptable.

62.4(1) To request a variance, the licensee must:

- a.* Apply in writing on a form provided by the department;
- b.* Cite the rule or rules from which a variance is desired;
- c.* State why compliance with the rule or rules cannot be accomplished;
- d.* Explain how the variance is consistent with the résumé of care or the individual program plan;
- e.* Demonstrate that the requested variance will not endanger the health, safety, welfare, or rights of any resident.

62.4(2) Upon receipt of a request for variance, the director shall:

- a.* Examine the rule from which the variance is requested;
- b.* Evaluate the requested variance against the requirement of the rule to determine whether the request is necessary to meet the needs of the residents;
- c.* Examine the effect of the requested variance on the health, safety, or welfare of the residents;
- d.* Consult with the applicant to obtain additional written information if required.

62.4(3) Based upon this information, approval of the variance will be either granted or denied within 120 days of receipt.

481—62.5(135C) General requirements.

62.5(1) The license shall be valid and be posted in each facility so the public can see it easily. (III)

62.5(2) The license shall be valid only for the premises and person named on the license and is not transferable.

62.5(3) The posted license shall accurately reflect the current status of the residential care facility for persons with mental illness. (III)

62.5(4) Licenses expire one year after the date of issuance or as indicated on the license.

62.5(5) There shall be no more beds erected than are stipulated on the license. (II, III)

62.5(6) Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

This rule is intended to implement Iowa Code section 135C.8.

481—62.6(135C) Notification required by the department. The department shall be notified:

Within 48 hours, by letter, of any reduction or loss of personal care or dietary staff lasting more than seven days which places the staff ratio below that required for licensing. No additional residents shall be admitted until the minimum staff requirements are achieved. (II, III)

Within 30 days of any proposed change in the résumé of care for the RCF/PMI. (II, III)

Thirty days before addition, alteration, or new construction is begun in the residential care facility or on the premises; (III)

Thirty days in advance of closure of the residential care facility for persons with mental illness; (III)

Within two weeks of any change of administrator; (II, III)

Within 30 days when any change in the category of license is sought. (III)

Prior to the purchase, transfer, assignment, or lease of a residential care facility the licensee shall:

1. Inform the department in writing of pending sale, transfer, assignment, or lease of the facility; (III)

2. Inform the department in writing of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)

3. Submit a written authorization to the department permitting the department to release information of whatever kind from the department's files concerning the licensee's residential care facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

After the authorization has been submitted to the department, the department shall upon request send or give copies of all recent licensure surveys and any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee or lessee. Costs for copies requested shall be paid by the prospective purchaser, transferee, assignee or lessee. No information personally identifying any resident shall be provided to prospective purchaser, transferee, assignee or lessee. (II, III)

This rule is intended to implement Iowa Code sections 135C.6(3) and 135C.16(2).

481—62.7(135C) Administrator. Each residential care facility for persons with mental illness shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these rules. (II, III)

62.7(1) The administrator shall be at least 21 years of age and shall meet at least one of the following conditions:

a. Be a licensed nursing home administrator, or a certified residential care administrator in Iowa. These individuals must have at least two years' experience in direct care or supervision of persons with mental illness, (II, III) or

b. Be a qualified mental health professional (QMHP) with at least one year of experience in an administrative capacity in a health care facility, (II, III) or

c. Have completed a one-year educational training program approved by the department with emphasis on serving the needs of persons with mental illness, and two years' experience in direct care or supervision of persons with mental illness. (II, III)

d. Those individuals currently employed as administrators on the effective date of these rules (March 30, 1988) shall not be required to meet the above criteria during their employment in the current facility.

62.7(2) The administrator shall be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II, III)

a. The distance between the two farthest facilities shall be no greater than 50 miles. (II, III)

b. An administrator of more than one facility must designate an administrative staff person in each facility who shall be responsible for directing programs in the facility during the administrator's absence. (II, III)

62.7(3) The administrative staff person shall be designated in writing and immediately available to the facility on a 24-hour basis when the administrator is absent and residents are in the facility. (II, III)

The person(s) designated shall:

- a. Have at least two years' experience or training in a supervisory or direct care position in a mental health setting; (II, III)
- b. Be knowledgeable of the operation of the facility; (II, III)
- c. Have access to records concerned with the operation of the facility; (II, III)
- d. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (II, III)
- e. Be at least 21 years of age; (III)
- f. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (II, III)
- g. Have training to carry out assignments and take care of emergencies and sudden illnesses of residents. (II, III)

62.7(4) If an administrator serves more than one facility, a written plan shall be developed and available for review and approval by the department designating regular and specific times the administrator will be available to meet with the staff and residents to provide direction and supervision of resident care and services. (II, III)

62.7(5) The licensee may be the approved administrator providing the requirements set forth in these rules are met. (III)

62.7(6) When a facility has been unable to replace the administrator, through no fault of its own, a provisional administrator meeting the qualifications of the administrative staff person may be appointed on a temporary basis by the licensee to assume the administrative responsibilities for the facility. This person shall not serve more than three months. The department must be notified before the appointment of the provisional administrator. (III)

A facility applying for initial licensing shall not have a provisional administrator. (III)

This rule is intended to implement Iowa Code section 135C.14(2).

481—62.8(135C) Administration.

62.8(1) The licensee shall:

- a. Be responsible for the overall operation of the RCF/PMI. (III)
- b. Be responsible for compliance with all applicable laws and with the rules of the department. (II, III)
- c. Establish written policies, which shall be available for review by the department or other agencies designated by Iowa Code section 135C.16(3), for the operation of the RCF/PMI including but not limited to: (III)
 - 1. Personnel (III)
 - 2. Admission (III)
 - 3. Evaluation services (II, III)
 - 4. Programming and individual program plan (II, III)
 - 5. Crisis intervention (II, III)
 - 6. Discharge or transfer (III)
 - 7. Medication management (II)
 - 8. Resident property (II, III)
 - 9. Financial affairs (II, III)
 - 10. Records (III)
 - 11. Health and safety (II, III)
 - 12. Nutrition (III)
 - 13. Physical facilities and maintenance (III)
 - 14. Care review (III)
 - 15. Resident rights (II, III)
- d. Furnish statistical information concerning the operation of the facility to the department within 30 days of request. (III)

62.8(2) The administrator shall be responsible for the implementation of procedures to support the policies established by the licensee. (III)

This rule is intended to implement Iowa Code section 135C.14.

481—62.9(135C) Personnel.

62.9(1) The personnel policies and procedures shall include the following requirements: (III)

a. Written job descriptions for all employees or agreements for all consultants, which include duties and responsibilities; education, experience, or other requirements, and supervisory relationships. (III)

b. Annual performance evaluation of all employees and consultants which is dated and signed by the employee or consultant and the supervisor. (III)

c. Personnel records which are current, accurate, complete, and confidential to the extent allowed by law. The record shall contain documentation of how the employee's or consultant's education and experience are relevant to the position for which hired. (III)

d. Roles, responsibilities, and limitation of student interns and volunteers. (III)

e. An orientation program for all newly hired employees and consultants which includes an introduction to the facility's personnel policies and procedures, and a discussion of the facility's safety plan. (II, III)

f. A plan for a continuing education program with a minimum of eight in-service programs per year for all employees which shall include a written, individualized staff development plan for each employee. This includes, but is not limited to, the administrator, department heads, and direct care staff. The plan shall take into consideration the needs of the facility as identified in the résumé of care. The plan shall ensure that each employee has the opportunity to develop and enhance skills and to broaden and increase knowledge contributing to effective resident care, including but not limited to: (II, III)

(1) First aid. (II, III)

(2) Human needs and behavior. (II, III)

(3) Problems and needs of persons with mental illness. (II, III)

(4) Medication. (II, III)

(5) Crisis intervention. (II)

(6) Delivery of services in accordance with the principles of normalization. (III)

(7) Wellness. (III)

(8) Fire safety, disaster, and tornado preparation. (II, III)

g. Equal opportunity and affirmative action employment practices. (III)

h. Procedures to be used when disciplining an employee. (III)

i. Appropriate dress and personal hygiene for staff and residents. (III)

62.9(2) The facility shall require regular health examinations for all personnel, and examinations shall be required at the commencement of employment and thereafter at least every four years. The examination shall include, at a minimum, the health status of the employee. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (III)

a. No person shall be allowed to provide services in a facility if the person has a disease:

(1) Which is transmissible through required workplace contact, (I, II, III)

(2) Which presents a significant risk of infecting others, (I, II, III)

(3) Which presents a substantial possibility of harming others, and (I, II, III)

(4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

b. There shall be written policies for emergency medical care for employees in case of sudden illness or accident. These policies shall include the administrative individuals to be contacted. (III)

c. Health certificates for all employees shall be available for review by the department. (III)

62.9(3) Staffing. The facility shall establish, subject to approval of the department, the numbers and qualifications of the staff required in an RCF/PMI using as its criteria the services being offered as indicated on the résumé of care and as required for implementation of individual program plans. (II, III)

a. Personnel in an RCF/PMI shall provide 24-hour coverage for residential care services. Personnel shall be up and dressed at all times in facilities over 15 beds. In facilities with 15 or less beds, personnel shall be up and dressed when residents are awake. (II, III)

b. The policies and procedures shall provide for staff accessibility during normal sleeping hours in facilities with 15 beds or less. (I)

c. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. The policies and procedures shall provide for an on-call staff person to be available when residents and staff are absent from the facility. (II, III)

(1) The on-call staff person shall be designated in writing.

(2) Residents shall be informed of how to call the on-call person.

d. The staffing plan shall ensure that at least one qualified direct care staff is on duty to carry out and implement the individual program plans. (II, III)

e. The RCF/PMI shall provide for services of a qualified mental health professional by direct employment or contract and whose responsibilities shall include, but not be limited to: (II, III)

(1) Approval of each resident's individual program plan; (II, III)

(2) Monitoring the implementation of each resident's individual program plan; (II, III)

(3) Recording each resident's progress; (II, III)

(4) Participation in a periodic review of each individual program plan pursuant to 62.12(4) "a" and "b." (II, III)

f. Each residential care facility with over 15 beds shall employ a person to direct the activity program both inside and outside the facility in accordance with each resident's individual program plan. (III)

g. Staff for the activity program shall be provided on a minimum basis of 45 minutes per licensed bed per week:

(1) The activity coordinator shall have completed the activity coordinator's orientation course approved by the department within six months of beginning employment or have comparable training and experience as approved by the department. (III)

(2) The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. (III)

(3) There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

h. The activity coordinator shall have access to all residents' records excluding financial records; (III)

i. Responsibilities of the activity coordinator shall include:

(1) Coordinating all activities, including volunteer or auxiliary activities and religious services. (III)

(2) Keeping all necessary records including attendance, individual resident progress notes at least quarterly, and monthly calendars prepared one month in advance. (III)

(3) Coordinating the activity program with all other services in the facility. (III)

(4) Participating in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

62.9(4) Personnel record. A personnel record shall be kept for each employee. (III)

a. The record shall include the employee's:

1. Name and address, (III)

2. Social security number, (III)

3. Date of birth, (III)

4. Date of employment, (III)

5. References, (III)

6. Position in the facility, (III)

7. Job description, (III)

8. Documentation of experience and education, (III)

9. Staff development plan, (III)

10. Annual performance evaluation, (II, III)
11. Documentation of disciplinary action, (II, III)
12. Date and reason for discharge or resignation, (III)
13. Current physical examination. (III)

b. The personnel records shall be made available to the long-term care resident's advocate/ombudsman of the department on aging in response to a complaint being investigated.

62.9(5) Personnel histories.

a. Each health care facility shall submit a form specified by the department of public safety to the department of public safety, and receive the results of a criminal history check and dependent adult abuse record check before any person is employed in a health care facility. The health care facility may submit a form specified by the department of human services to the department of human services to request a child abuse history check. For the purposes of this subrule, "employed in a facility" shall be defined as any individual who is paid, either by the health care facility or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors), to provide direct or indirect treatment or services to residents in a health care facility. 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 requirements of this subrule are individuals such as building contractors, repair workers or others who are in a facility for a very limited purpose, are not in the facility on a regular basis, and who do not provide any treatment or services to the residents of the health care facility. (I, II, III)

b. A person who has a criminal record or founded dependent adult abuse report cannot be employed in a health care facility unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse report does not merit prohibition from employment. (I, II, III)

c. Each health care facility shall ask each person seeking employment in a facility "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of crime in this state or any other state?" The person shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The person shall indicate, by signature, that the person has been informed that the record checks will be conducted. (I, II, III)

d. If a person has a record of founded child abuse in Iowa or any other state, the person shall not be employed in a health care facility unless the department of human services has evaluated the crime or founded report and concluded that the report does not merit prohibition of employment. (I, II, III)

e. Proof of dependent adult abuse and criminal history checks may be kept in files maintained by the temporary employee agencies and contractors. Facilities may require temporary agencies and contractors to provide a copy of the results of the dependent adult abuse and criminal history checks. (I, II, III)

This rule is intended to implement Iowa Code sections 135C.14(2) and 135C.14(6).
[ARC 0663C, IAB 4/3/13, effective 5/8/13]

481—62.10(135C) General admission policies. There shall be admission policies which address the following:

1. No resident shall be admitted or retained who is in need of greater services than the facility can provide. (II, III)
2. Residents shall be admitted only on a written order signed by a physician certifying that the individual requires no more than personal care and supervision and does not require nursing care. (II, III)
3. A preplacement visit shall be completed prior to admission, except in case of an emergency admission or readmission, to familiarize the applicant with the facility and services offered. The policies and procedures may allow for waiving the requirement at the request of a person seeking admission when the completion of the visit would create a hardship for the person seeking admission. If the distance to be

traveled makes it impossible to complete the visit in an eight-hour day, this may be considered to create a hardship. (III)

4. Prior to admission of an applicant, the facility shall obtain sufficient information to determine if its program is appropriate and adequate to meet the person's needs. (III)

5. Admission criteria shall include but not be limited to age, sex, diagnosis, from the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, substance abuse, dual diagnosis and criteria that are consistent with the résumé of care. (III)

6. Each facility shall maintain a waiting list with selection priorities identified. (III)

7. No RCF/PMI may admit more residents than the number of beds for which it is licensed. (II, III)

8. There shall be a written, organized orientation program for all residents which shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the health care, recovery, and rehabilitation of the individual and which shall be available for review by the department. (III)

9. Infants and children under the age of 18 shall not be admitted to an RCF/PMI for adults unless given prior written approval by the department. A distinct part of an RCF/PMI, segregated from the adult section, may be established based on a résumé of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

This rule is intended to implement Iowa Code sections 135C.3 and 135C.23.

481—62.11(135C) Evaluation services.

62.11(1) Each resident admitted shall have had a physical examination prior to admission and annually thereafter. (II, III)

a. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be part of the record in lieu of an additional physical examination. (II, III)

b. The record of the admission physical examination shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, physical examination, diagnosis, statement of chief complaints, and results of any diagnostic procedure. (II, III)

c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (II, III)

62.11(2) Evaluation services shall be provided to each resident. An annual evaluation of each resident shall be completed no later than 12 months from the date of the last available evaluation. For residents who are on leave from a state mental health institution, the institution shall be responsible for the completion of the evaluation. The facility shall ensure the completion of the evaluation of all other residents. The annual evaluation shall identify physical health and current level of functioning and need for services. (II, III)

62.11(3) The portion of the evaluation to identify the resident's physical health shall:

a. Result in identification of current illness and disabilities and recommendations for physical and physiological treatment and services. (II, III)

b. Include an evaluation of the resident's ability for health maintenance. (III)

c. Be performed by a medical doctor or doctor of osteopathic medicine who holds a current license to practice medicine in the state of Iowa. If the evaluation is completed out of Iowa, it must be by a physician who holds a current license in the state in which the evaluation is performed. (II, III)

62.11(4) The portion of the evaluation to identify the resident's current functioning level and need for services shall:

a. Identify the resident's level of functioning and need for services in each of the following areas: self-care, community living skills, psychotherapeutic treatment, vocational skills, academic skills. (II, III)

b. Be of sufficient detail to determine the appropriateness of placement according to the skills and needs of the resident. (II, III)

c. Be made without regard to the availability of services. (III)

d. Be performed by a QMHP, in consultation with the interdisciplinary team. (II, III)

e. If an evaluation is available from the referral source, the evaluation shall be secured by the facility prior to the admission of the applicant. (III)

f. If an evaluation is not available, or does not contain all the required information, the facility shall ensure an evaluation to the extent necessary to determine if the applicant meets the criteria for admission. For those admitted, the remainder of the evaluation shall be performed prior to the development of an individual program plan. (III)

g. Results of all evaluations shall be in writing and maintained in the resident's record. Evaluations subsequent to the initial evaluation shall be performed in sufficient detail to determine changes in the resident's physical health, skills and need for services. (II, III)

62.11(5) A narrative social history shall be completed for each resident within 30 days of admission and approved by the qualified mental health professional prior to the development of the IPP. (III)

a. When the social history was secured from another provider, the information contained shall be reviewed within 30 days of admission. The date of the review, signature of the staff reviewing the history and a summary of significant changes in the information shall be entered in the resident's record. (III)

b. An annual review of the information contained within the social history shall be incorporated into the individual program plan progress note. (III)

c. The social history shall minimally address the following areas:

1. Referral source and reason for admission, (II, III)

2. Legal status, (II, III)

3. A description of previous living arrangements, (III)

4. A description of previous services received and summary of current service involvements, (II, III)

5. A summary of significant medical conditions including, but not limited to, illnesses, hospitalizations, past and current drug therapies, and special diets, (II, III)

6. Substance abuse history, (II, III)

7. Work history, (III)

8. Educational history, (III)

9. Relationship with family, significant others, and other support systems, (III)

10. Cultural and ethnic background and religious affiliation, (II, III)

11. Hobbies and leisure time activities, (III)

12. Likes, dislikes, habits, and patterns of behavior, (II, III)

13. Impressions and recommendations.

This rule is intended to implement Iowa Code section 135C.14(7).

[ARC 0663C, IAB 4/3/13, effective 5/8/13]

481—62.12(135C) Programming.

62.12(1) Individual program plan. An individual program plan (IPP) for each resident shall be developed by an interdisciplinary team. Services to the resident shall be appropriate to address the short-term transitional or long-term residential needs of the resident. The resident or the resident's legal guardian has the ultimate authority to accept or reject the plan unless otherwise determined by the court. The IPP shall be approved and implementation monitored by the QMHP. (II, III)

a. The IPP shall be based on the individual service plan of the referring agency, if available, the information contained in the social history, the need for services identified in the evaluation, and any other pertinent information. (III)

b. The facility shall assist the resident in obtaining access to academic, community living skills training, legal, self-care training, support, transportation, treatment, and vocational training services to the resident as needed. These services may be provided by the facility or obtained from other providers. (III)

c. Services to the resident shall be provided in the least restrictive environment and shall incorporate the principle of normalization. (III)

d. If needed services are not available and accessible, the facility shall document the actions which were taken to locate and access or deliver those services. The documentation shall include the identification of the type of needs which will not be met due to the lack of available services. (III)

e. The IPP shall be developed within 30 days following admission to the facility and renewed at least annually. (II, III)

f. The IPP shall be in writing, dated, signed by the interdisciplinary team members, and maintained in the resident's record. (III)

g. Written notice of the meeting to develop an IPP shall be sent to all persons to be included in the interdisciplinary team conference in advance of the scheduled meeting. (III)

62.12(2) The IPP shall include the following:

1. Goals, (III)

2. Objectives, (III)

3. The specific service(s), including medication counseling, to be provided to achieve the objectives, the person(s) or agency(ies) responsible for providing the service(s), and the date of initiation and anticipated duration of service(s). (III)

62.12(3) The IPP shall state the evaluation procedure for determining if objectives are achieved which shall include the incorporation of a continuous process for review and revision. (III)

62.12(4) There shall be a review of the IPP by relevant staff, the resident, and appropriate others at least semiannually. (II, III)

a. The review shall include the development of a written report which addresses the following: summary of the resident's progress toward objectives; the need for continued services and any recommendation concerning alternative services or living arrangements; and any recommended change in guardianship or conservatorship status. The report shall reflect those involved in the review and the date of the review, and shall be maintained in the resident's record. (II, III)

b. The review shall be approved by the qualified mental health professional. (III)

62.12(5) There shall be procedures for recording the activities of each service provider toward assisting the resident in achieving the objectives in the IPP and the resident's response which shall include a mechanism for coordination with all service providers. (III)

a. An entry into the resident's record shall be made by staff whenever possible at the time of service provision but no later than seven days from service provision. (III)

b. Entries shall be dated and signed by the person providing the service. (III)

c. When the service includes ongoing activities occurring more than once a week, a summarized entry may be made weekly by staff in the resident's record. (III)

d. Entries shall be written in terms of behavioral observations and specific activities. Entries that involve subjective interpretations of a resident's behavior or progress shall be clearly identified and shall be supplemented with the behavioral observations which served as the basis of the interpretation. (III)

This rule is intended to implement Iowa Code section 135C.14.

481—62.13(135C) Crisis intervention.

62.13(1) There shall be written policies and procedures concerning crisis intervention. (II) These policies and procedures shall be:

a. Directed to maximizing the growth and development of the individual by incorporating a hierarchy of available alternative methods that emphasize positive approaches; (II, III)

b. Available in each program area and living unit; (II, III)

c. Available to individuals and their families; and (II, III)

d. Developed with the participation, as appropriate, of individuals served. (II, III)

62.13(2) Corporal punishment and verbal abuse (shouting, screaming, swearing, name-calling, or any other activity that would be damaging to an individual's self-respect) are prohibited by written policy. (II)

62.13(3) Medication shall not be used as punishment, for the convenience of staff, or as a substitute for a program. Direct care staff shall monitor residents on medication and notify the physician if a resident is too sedated to participate in IPP. (I, II)

62.13(4) Residents shall not be subjected to mechanical restraint. (I, II)

62.13(5) There shall be written policies that define the uses of seclusion and physical restraints, designate the staff member(s) who may authorize its use, and establish a mechanism for monitoring and controlling its use. (I, II) Temporary physical restraint and temporary seclusion of residents shall be used only under the following conditions: (I, II)

a. An emergency to prevent injury to the resident or to others; or (I, II)

b. For crisis intervention but shall not be used for punishment, for the convenience of staff or as a substitution for supervision or program; (I, II) and

c. Seclusion may only be used in an RCF/PMI if a variance is granted. When a seclusion room is used, it shall meet the standards set out in 481—subrule 61.5(12). (I, II)

62.13(6) The physician and QMHP shall be notified immediately of the resident's need for placement in seclusion and a time-limited order for seclusion obtained from the physician. The order shall be for no more than one hour at a time. If the resident is placed in seclusion longer than one hour, the resident shall be visited and evaluated by the physician or qualified mental health professional before a continuation of the seclusion order can be obtained. If the evaluation is conducted by a QMHP, the physician shall be notified of the resident's condition and the physician shall see the resident within 24 hours of each incident of seclusion and sign the seclusion order. (I, II)

62.13(7) If orders for seclusion remain in force for more than a total of 3 hours in a 24-hour period, the facility shall make arrangements for immediate transfer of the resident to a higher level of care. (I, II)

62.13(8) Standing or PRN orders for seclusion are prohibited. (I, II)

62.13(9) Written documentation of the above information shall be kept as a part of each resident's record and the administrator shall be responsible for maintaining a daily record of seclusion usage which shall be kept available for review by the department. (II, III)

62.13(10) Written documentation shall be kept of each incident of seclusion to minimally include: (II)

a. Explanation of less restrictive measures implemented prior to use of seclusion, (I, II)

b. Record of visual observation of the resident every ten minutes or more frequently if needed, (I)

c. Description of the resident's activity at the time of observation to include verbal exchange and behavior, (I, II)

d. Description of safety procedures taken (removal of dangerous objects, etc.), (I)

e. Record of vital signs including blood pressure, pulse and respiration unless contraindicated by resident behavior and reasons documented, (I, II)

f. Record of intake of food and fluid, (II, III)

g. Record of rest room use, (II, III)

h. Record of numbers of hours and minutes in seclusion. (II)

62.13(11) The facility shall provide training by qualified professionals to the staff on physical restraint and seclusion theory and techniques. (I)

a. The facility shall keep a record of above training for review by the department and shall include attendance. (II, III)

b. Only staff who have documented training in physical restraint and seclusion theory and techniques shall be authorized to assist with seclusion or physical restraint of a resident. (I)

c. Under no circumstances shall a resident be allowed to actively or passively assist in the restraint of another resident. (I)

This rule is intended to implement Iowa Code section 135C.14.

481—62.14(135C) Discharge or transfer. Procedures for the discharge or transfer of the resident shall be established and followed: (II, III)

62.14(1) The decision to discharge a person and the plan for doing so shall be established through the participation of the resident, members of the interdisciplinary team and other resource personnel as appropriate for the welfare of the individual. (II, III)

a. Discharge planning shall begin within 30 days of admission and be carried out in accordance with the IPP. (II, III)

b. As changes occur in a resident's physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, the resident shall be transferred promptly to another appropriate facility pursuant to 62.10(1) "a." (I, II)

c. Notification shall be made to the next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

d. Proper arrangements shall be made for the welfare of the resident prior to the transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

e. The licensee shall not refuse to discharge or transfer a resident when directed by the physician, resident, legal representative, or court. (II, III)

f. Advance notification by telephone shall be made to the receiving facility prior to the transfer of any resident. (III)

g. When a resident is transferred or discharged, the current evaluation and treatment plan and progress notes for the last 30 days, as set forth in these rules, shall accompany the resident. (II, III)

h. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

i. A discharge or transfer authorization and summary shall be prepared for each resident who has been discharged or transferred from the facility and shall be disseminated to appropriate persons to ensure continuity of care and in accordance with the requirements to ensure confidentiality. (II, III)

j. A transfer to a part of a facility that has a different license must be handled the same way as a transfer to another facility, and not as an intrafacility transfer.

62.14(2) Intrafacility transfer. Residents shall not be moved from room to room within a health care facility arbitrarily. (I, II)

a. Involuntary relocation may occur only to implement goals and objectives in the IPP and in the following situations:

(1) Incompatibility with or behavior disturbing to roommates, as documented in the residents' records; (I, II)

(2) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex; (II, III)

(3) Reasonable and necessary administrative decisions regarding the use and functioning of the building. (II, III)

b. Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident or legal guardian include:

(1) Punishment or behavior modification. (II)

(2) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph "a," the resident shall be notified at least 48 hours prior to the transfer and the reason shall be explained. The legal guardian shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or legal guardian. (II)

d. If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family and legal guardian shall be notified immediately, or as soon as possible, of the condition requiring emergency relocation and the notification shall be documented. (II)

62.14(3) Involuntary discharge or transfer. Residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C which states that a resident shall be transferred or discharged only for the following:

a. Medical reasons which include:

(1) Acute stage of alcoholism, mental illness, or an active state of a communicable disease, (I, II)

or

(2) Need for medical procedures as determined by a physician, or services which cannot be or are not being carried out in the facility. (I, II)

b. Resident's welfare or welfare of other residents which includes a resident who is dangerous to the resident or other residents (I), or

c. Nonpayment except as prohibited by Medicaid. (II)

62.14(4) Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. (II) The 30-day requirement shall not apply in any of the following instances:

a. If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and written medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff. (I, II)

b. If the transfer or discharge is subsequently agreed to by the resident or by the resident's legal guardian, and notification is given to the legal guardian, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

(1) The notice required by 62.14(4) shall contain all of the following information:

1. The stated reason for the proposed transfer or discharge. (II)

2. The effective date of the proposed transfer or discharge. (II)

3. The following statement must be included:

"You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals (hereinafter referred to as department) within seven days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration date of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Iowa Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319." (II)

(2) A request for a hearing made under 62.14(4) "b"(1) shall stay a transfer or discharge pending a hearing or appeal decision. (II)

(3) The type of hearing shall be determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the licensee, resident, legal guardian, and Iowa department on aging long-term care resident's advocate/ombudsman of record, not later than five full business days after receipt of the request. This notice shall also inform the licensee, resident, or legal guardian that they have a right to appear at the hearing in person or be represented by their attorneys or other individual. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department on aging's long-term care resident's advocate/ombudsman shall have the right to appear at the hearing. (II)

(4) The hearing shall be heard by a department of inspections and appeals hearing officer pursuant to department rules. The licensee or designee shall have the opportunity to present oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and legal guardian shall also have an opportunity to present oral testimony or written material to show just cause why a transfer or discharge should not be made; the burden of proof rests on the party requesting the transfer or discharge. (II)

(5) Based upon all testimony and material submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by regular mail to the licensee, resident, responsible party, and department on aging long-term

care ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision. (II)

(6) A copy of the notice required by 62.14(4) shall be personally delivered to the resident and a copy placed in the resident's record. A copy shall also be transmitted to the department, the resident's legal guardian, physician, the person or agency responsible for the resident's placement, maintenance, and care in the facility, and the department on aging's long-term care resident's advocate/ombudsman. (II)

(7) If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

(8) The involuntary transfer or discharge shall be discussed with the resident, legal guardian, and the person or agency responsible for the resident's placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and shall be made a part of the resident's record. (II)

(9) The resident shall receive counseling services before (by sending facility) and after (by receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident's record. Counseling shall be provided by a qualified individual who meets one of the following criteria: (II)

1. Has a bachelor's or master's degree in social work from an accredited college. (II)
2. Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with a public or private agency. (II)
3. Has been employed in a social work capacity for a minimum of four years in a public or private agency. (II)
4. Is a licensed psychologist or psychiatrist. (II)

(10) The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be discharged or transferred. (II)

(11) The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

(12) In the case of an emergency transfer or discharge as outlined in 62.14(4) "a," the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident's file and it must contain all the information required by 62.14(4) "b"(1)"1" and "2." In addition, the notice must contain a statement in not less than 12-point type, which reads:

"You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa department of inspections and appeals within seven days after receiving this notice. You have the right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to

the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.”

A hearing requested pursuant to this subrule shall be held in accordance with 62.14(4) “b”(3), (4) and (5). (II)

(13) Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility’s license by the department. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities. (II)

This rule is intended to implement Iowa Code sections 135C.14(8), 135C.31, 135C.43, and 135C.46.

481—62.15(135C) Medication management.

62.15(1) Medications shall be prescribed on an individual basis by one who is authorized by Iowa law to prescribe. (I, II)

a. Medication orders shall be correctly implemented by qualified personnel. (II)

b. Qualified staff shall ensure that residents are able to take their own medication. (I, II)

c. Each physician order allowing a resident to take their own medications shall specify whether this self-medication shall be without supervision or under the supervision of qualified staff as defined in 62.15(2). (I, II)

62.15(2) Drug administration.

a. A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

b. The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

c. This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

d. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved residential aide course, nurse aide course, nurse aide training and testing program or nurse aide competency examination;

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

e. A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program’s pharmacology or clinical instructor indicating the individual is competent in medication administration.

f. A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph “d” of this subrule do not apply to this individual.

g. Unit dose medication shall remain in the identifiable unit dose package until given to the resident. (II)

h. Medications that are not contained in unit dose packaging shall be set up and administered by the same person and must be administered within one hour of preparation. (II)

i. The person administering medications must observe and check to make sure the resident swallows oral medications and must record the date, time, amount and name of each medication given. (II)

j. Injectable medications shall be administered by a qualified nurse or physician.

k. Residents certified by their physician as capable of injecting their own insulin may do so. Insulin may be administered pursuant to “*j*” above or as otherwise authorized by the resident’s physician. Authorization by the physician shall:

- (1) Be in writing,
- (2) Be maintained in the resident’s record,
- (3) Be renewed quarterly,
- (4) Include the name of the individual authorized to administer the insulin,
- (5) Include documentation by the physician that the authorized person is qualified to administer insulin to that resident.

l. Current and accurate records must be kept on the receipt and disposition of all Schedule II drugs. (II, III)

62.15(3) For each resident who is taking medication with or without supervision there shall be documentation on the individual’s record to include:

- a.* Name of resident, (II, III)
- b.* Name of drug, dose, and schedule, (II, III)
- c.* Method of administration, (II, III)
- d.* Drug allergies and adverse reactions, (I, II)
- e.* Special precautions, (I, II)
- f.* Documentation of resident’s continuing ability to administer own medication. (I, II)

62.15(4) Medication counseling shall be provided for all residents in accordance with the IPP on an ongoing basis and as part of discharge planning unless contraindicated in writing by the physician with reasons and pursuant to 62.12(2) “*c.*” (II, III)

Each resident shall be given verbal and written information about all medications the resident is currently using, including over-the-counter medications. A suggested reference is “USPDI, Advice for the Patient.” (II, III)

The information shall include:

- a.* Name, reason for, and amount of medication to be taken; (II)
- b.* Time medication is to be taken and the reason that schedule was established; (II)
- c.* Possible benefits, risks and side effects of each medication including over-the-counter medications; (II)
- d.* The names of people in the community qualified to answer questions about medications. (II, III)
- e.* A list of available resources or agencies which may assist the resident to obtain medication after discharge. (III)

62.15(5) Drug storage.

a. Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in their bedrooms. Individual locked storage shall be utilized. (II, III)

b. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

- (1) Adequate size cabinet with lock which can be used for storage of drugs, solutions, and prescriptions. A locked drug cart may be used. (II, III)
- (2) A bathroom shall not be used for drug storage. (II, III)
- (3) The drug storage cabinet shall be kept locked when not in use. (II, III)
- (4) The drug storage cabinet key shall be in the possession of the employee charged with the responsibility of administering medication. (III)
- (5) Medications requiring refrigeration which are stored in a common refrigerator shall be kept in a locked box properly labeled, and separated from food and other items. (III)

(6) Drugs for external use shall be stored separately from drugs for internal use. External medications are those to be applied to the outside of the body and include but are not limited to salves, ointments, gels, pastes, soaps, baths, and lotions. Internal medications are those to be applied inside the body or ingested and include but are not limited to oral and injectable medications, eye drops, ear drops and suppositories. Also, eye drops and ear drops shall be separated from each other as well as from other internal and external medications. (II, III)

(7) All potent, poisonous, or caustic materials shall be stored in a separate room from the medications. (II, III)

(8) Inspection of the condition of stored drugs shall be made by the administrator and a licensed pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but need not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current order, and drugs improperly stored. (III)

(9) Double-locked storage of Schedule II drugs shall not be required under single unit package drug distribution systems in which the quantity stored does not exceed a seven-day supply and a missing dose can be readily detected but must be kept in a locked medication cabinet. Quantities in excess of a seven-day supply must be double-locked. (II)

c. Bulk supplies of prescription drugs shall not be kept. (III)

62.15(6) Drug safeguards.

a. All labels on medications must be legible. If labels are not legible, the medication shall be sent back to the dispenser as defined in Iowa Code section 147.107 for relabeling. (II, III)

b. The medication for each resident shall be kept or stored in the original dispensed containers. (II, III)

c. The facility shall adopt policies and procedures for the destruction of unused prescription drugs for residents who have died. The policies and procedures shall include, but not be limited to, the following: (III)

(1) Drugs shall be destroyed by the person in charge in the presence of the administrator or the administrator's designee;

(2) Notation of the destruction shall be made in the resident's chart, with signatures of the persons involved in the destruction;

(3) The manner in which the drugs are disposed of shall be identified (i.e., incinerator, sewer, landfill). (II, III)

d. The facility shall also adopt policies and procedures for the disposal of controlled substances dispensed to residents whose administration has been discontinued by the prescriber. These policies and procedures shall include, but not be limited to, the following:

(1) Procedures for obtaining a release from the resident;

(2) The manner in which the drugs were destroyed and by whom, including witnesses to the destruction;

(3) Mechanisms for recording the destruction;

(4) Procedures to be used when the resident or the conservator or guardian refuses to grant permission for destruction. (II, III)

e. The facility shall adopt policies and procedures for the disposal of unused discontinued medication. The procedures shall include but not be limited to:

(1) A specified time after which medication must be destroyed, sent back to the dispenser or placed in long-term storage;

(2) Procedures for obtaining permission of the resident, or the conservator or guardian;

(3) Procedures to be used when the resident or conservator or guardian refuses to grant permission for disposal;

(4) Unused discontinued medication shall be locked and shall be separate from current medication. (II, III)

f. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time

period. The automatic stop order may vary for different types of drugs. The facility, in consultation with a physician or pharmacist serving the home, shall institute policies and provide procedures. These shall be provided to all prescribers and pharmacists serving the facility and conveniently located for personnel administering medications. (III)

g. Residents shall not keep any prescription medication in their possession unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. Over-the-counter medications may be maintained provided they are in a locked container and pursuant to subrule 62.16(5). (I, II)

h. No prescription drugs shall be administered to a resident without a written order signed by a person qualified to prescribe the medication and renewed quarterly. (II)

i. Prescription drugs shall be reordered only with the permission of the attending prescriber. (II, III)

j. No medications prescribed for one resident may be administered to or allowed in the possession of another. (II)

k. Residents on prescribed medication may maintain over-the-counter medication pursuant to 62.15(6) "g" unless contraindicated by the physician. The facility shall request this information from the physician and document in the resident's record. (II)

62.15(7) Each facility shall have policies and procedures established to govern the administration of prescribed medications to residents on leave from the facility. (III)

a. Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident's name, the facility, the medication, its strength, dose, and time of administration.

b. Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

c. Medication distributed as above may be issued only by facility personnel responsible for administering medication.

62.15(8) Each RCF/PMI that administers controlled substances shall obtain annually a registration issued by the board of pharmacy pursuant to Iowa Code section 124.302(1). (III)

This rule is intended to implement Iowa Code section 135C.14.

481—62.16(135C) Resident property.

62.16(1) The admission of a resident does not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal guardian. (II, III)

62.16(2) The admission of a resident shall not grant the RCF/PMI the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the resident's safety and for safe and orderly management of the residential care facility as required by these rules and in accordance with the IPP. (III)

62.16(3) An RCF/PMI shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

62.16(4) Resident's funds held by the RCF/PMI shall be in a trust account and kept separate from funds of the facility. (III)

62.16(5) No administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident or the resident's property, unless the resident is related to the person acting as guardian within the third degree of consanguinity. (III)

62.16(6) If a facility is a county care facility and upon the verified petition of the county board of supervisors, the district court may appoint the administrator of a county care facility as conservator or

guardian or both of a resident of that county care facility without fee. The administrator may establish either separate or common bank accounts for cash funds of these residents. (III)

This rule is intended to implement Iowa Code section 135C.24.

481—62.17(135C) Financial affairs. Each resident who has not been assigned a guardian or conservator by the court may manage the resident's personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

62.17(1) The facility shall maintain a written account of all the resident's funds received by or deposited with the facility. (II)

- a.* An employee shall be designated in writing to be responsible for resident accounts. (II)
- b.* The facility shall keep on deposit personal funds over which the resident has control.
- c.* If the resident requests these funds, they shall be given to the resident with a receipt maintained by the facility and a copy to the resident. If a conservator or guardian has been appointed for the resident, the conservator or guardian shall designate the method of disbursing the resident's funds. (II)
- d.* If the facility makes a financial transaction on a resident's behalf, the resident or the resident's legal guardian or conservator must receive or acknowledge having seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)
- e.* A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

f. A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

62.17(2) Contracts. There shall be a written contract between the facility and each resident which meets the following requirements:

- a.* State the base rate or scale per day or per month, the services included, and the method of payment; (III)
- b.* Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate; (III)
- c.* Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in subrule 62.17(2); (III)
- d.* State the method of payment of additional charges; (III)
- e.* Contain an explanation of the method of assessment of additional charges and an explanation of the method of periodic reassessment, if any, resulting in charging the additional charges; (III)
- f.* State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc. (III)
- g.* Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the program assessment at the time of admission, which is determined in consultation with the administrator. (III)
- h.* Include the total fee to be charged initially to the specific resident. (III)
- i.* State the conditions whereby the facility may make adjustments to its overall fees for residential care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:
 - (1) Written notification to the resident and responsible party, when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to the effective date of changes; (III)

(2) Notification to the resident and payor when appropriate, of changes in additional charges based on a change in the resident's condition. Notification must occur prior to the date the revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)

(3) State the terms of agreement in regard to refund of all advance payments, in the event of transfer, death, or voluntary or involuntary discharge. (III)

j. State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's legal representative.

(1) The facility shall ask the resident or legal representative if they want the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

(2) The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

k. State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

l. State the conditions of voluntary discharge or transfer; (III)

m. Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter; (III)

62.17(3) Each party shall receive a copy of the signed contract. (III)

This rule is intended to implement Iowa Code sections 135C.24 and 135C.23(1).

481—62.18(135C) Records.

62.18(1) *Resident record.* The licensee shall keep a permanent record about each resident with all entries current, dated, and signed. (II) The record shall include:

- a.* Name and previous address of resident; (III)
- b.* Birth date, sex, and marital status of resident; (III)
- c.* Church affiliation; (III)
- d.* Physician's name, telephone number, and address; (III)
- e.* Dentist's name, telephone number, and address; (III)
- f.* Name, address and telephone number of next of kin or legal representative; (III)
- g.* Name, address and telephone number of the person to be notified in case of emergency; (III)
- h.* Funeral director, telephone number, and address; (III)
- i.* Pharmacy name, telephone number, and address; (III)
- j.* Results of evaluation pursuant to 62.11(135C); (III)
- k.* Certification by the physician that the resident requires no more than personal care and supervision, but does not require nursing care; (III)
- l.* Physician's orders for medication and treatments shall be in writing and signed by the physician quarterly; diet orders shall be renewed yearly; (III)
- m.* A notation of yearly or other visits to physician or other professionals, all consultation reports and progress notes; (III)
- n.* Any change in the resident's condition; (II, III)
- o.* A notation describing the resident's condition on admission, transfer, and discharge; (III)
- p.* In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)
- q.* A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)
- r.* Disposition of personal property; (III)
- s.* Copy of IPP pursuant to 62.12(1); (III)
- t.* Progress notes pursuant to 62.12(4) and 62.12(5). (III)

62.18(2) *Confidentiality of resident records.* The facility shall have policies and procedures providing that each resident shall be ensured confidential treatment of all information, including

information contained in an automatic data bank. The resident's or the resident's legal guardian's written informed consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

A release of information form shall be used which includes to whom the information shall be released, the reason for the information being released, how the information is to be used, and the period of time for which the release is in effect. A third party, not requesting the release, shall witness the release of information form. (II)

a. The facility shall limit access to any resident records to staff and consultants providing professional service to the resident. Information shall be made available to staff only to the extent that the information is relevant to the staff person's responsibilities and duties. (II)

Only those personnel concerned with financial affairs of the residents may have access to the financial information. This is not meant to preclude access by representatives of state or federal regulatory agencies. (II)

b. The resident, or the resident's legal guardian, shall be entitled to examine all information and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician or QMHP determines the disclosure of the record or section is contraindicated in which case this information will be deleted prior to making the record available to the resident. This determination and the reasons for it must be documented in the resident's record by the physician or qualified mental health professional in collaboration with the resident's interdisciplinary team. (II)

62.18(3) Incident records.

a. Each RCF/PMI shall maintain an incident record report and shall have available incident report forms. (II, III)

b. The report of every incident shall be in detail on a printed incident report form. (II, III)

c. The person in charge at the time of the incident shall oversee the preparation and sign the report. (III)

d. A copy of the incident report shall be kept on file in the facility available for review and a part of administrative records. (III)

62.18(4) Retention of records.

a. Records shall be retained in the facility for five years following termination of services to the resident even when there is a change of ownership. (III)

b. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

This rule is intended to implement Iowa Code section 135C.24.

481—62.19(135C) Health and safety.

62.19(1) Physician. Each resident shall have a designated licensed physician who may be called when needed. (III)

62.19(2) Emergency care. The facility shall have written policies and procedures for emergency medical or psychiatric care to include:

a. A written agreement with a hospital or psychiatric facility or documentation of attempt to obtain a written agreement for the timely admission of a resident who, in the opinion of the attending physician, requires inpatient services; (II, III)

b. Provisions consistent with Iowa Code chapter 229; (II, III)

c. Immediate notification by the person in charge to the physician or QMHP, as appropriate, of any accident, injury or adverse change in the resident's condition. (I, II)

62.19(3) First-aid kit. A first-aid emergency kit shall be available on each floor in every facility. (II, III)

62.19(4) Infection control. Each facility shall have a written and implemented infection control program addressing the following:

a. Techniques for hand washing consistent with Guidelines for Handwashing and Hospital Control, 1985, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923404; (I, II, III)

b. Techniques for handling of blood, body fluids, and body wastes consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

c. Dressings, soaks, or packs; (I, II, III)

d. Infection identification; (I, II, III)

e. Resident care procedures to be used when there is an infection present consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

f. Sanitation techniques for resident care equipment; (I, II, III)

g. Techniques for sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags; (I, II, III)

h. Techniques for use and disposal of needles, syringes, and other sharp instruments consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

CDC Guidelines may be obtained from the U.S. Department of Commerce, Technology Administration, National Technical Information Service, 5285 Port Royal Rd., Springfield, Virginia 22161 (1-800-553-6847).

62.19(5) Aseptic techniques. If a resident needs any of the treatment or devices on the list below, written and implemented procedures regarding aseptic techniques shall be followed.

a. Intravenous or central line catheter consistent with Guideline for Prevention of Intravascular Device Related Infections, Centers for Disease Control, U.S. Department of Health and Human Services, PB97-130074, (I, II, III)

b. Urinary catheter, (I, II, III)

c. Respiratory suction, oxygen or humidification, (I, II, III)

d. Decubitus care, (I, II, III)

e. Tracheostomy, (I, II, III)

f. Nasogastric or gastrostomy tubes, (I, II, III)

g. Sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags. (I, II, III)

62.19(6) Dental services. Personnel shall assist residents to obtain regular and emergency dental services and provide necessary transportation. Dental services shall be performed only on the request of the resident or legal guardian. The resident's physician shall be advised of the resident's dental problems. (III)

62.19(7) Safe environment. The licensee of an RCF/PMI is responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II) The RCF/PMI shall meet the fire and safety rules and regulations as promulgated by the state fire marshal. (I, II)

62.19(8) Disaster. The licensee shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (II, III)

a. The plan shall be posted. (II, III)

b. Training shall be provided to ensure that all employees and residents are knowledgeable of the emergency plan. The training shall be documented. (II, III)

c. Residents shall be permitted to smoke only in posted areas where proper facilities are provided. Smoking by residents considered to be careless shall be prohibited except under direct supervision and in accordance with the IPP. (II, III)

62.19(9) Safety precautions. The facility shall take reasonable measures to ensure the safety of residents and shall involve the residents in learning the safe handling of household supplies and equipment in accordance with the policies and procedures established by the facility. (II)

a. All potent, poisonous, or caustic materials shall be plainly labeled and stored in a specific locked, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons. (I, II)

b. Residents shall have access to storage areas for cleaning and laundry supplies as appropriate to the activities being performed unless contraindicated in their IPP. (I, II)

62.19(10) Hazards. Entrances, exits, steps, and outside steps and walkways shall be kept free from ice, snow, and other hazards. (II, III)

62.19(11) Laundry. All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

a. Except for related activities, the laundry room shall not be used for other purposes. (III)

b. Resident's personal laundry shall be marked with an identification unless the resident is responsible for doing the resident's own laundry as indicated in the individual program plan. (III)

c. There shall be an adequate supply of clean, stain-free linens so that each resident shall have at least three washcloths, hand towels, and bath towels. (III)

d. Each bed shall be provided with clean, stain-free, washable bedspreads and sufficient lightweight serviceable blankets. A complete change of bed linens shall be available for each bed. (III)

62.19(12) Supplies, equipment, and storage.

a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. These may include: books (standard and large print), magazines, newspapers, radio, television, bulletin boards, board game, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, and outdoor equipment. Supplies and equipment shall be appropriate to the chronological age of the residents. (III)

b. Storage shall be provided for recreational equipment and supplies. (III)

This rule is intended to implement Iowa Code section 135C.14(1).

481—62.20(135C) Nutrition.

62.20(1) There shall be policies and procedures written and implemented for dietary staffing.

a. The person responsible for planning menus and monitoring the kitchens in each facility shall have completed training, approved by the department, in sanitation and food preparation. (III)

b. In facilities licensed for over 15 beds, food service personnel shall be on duty during a 12-hour span extending from the preparation of breakfast through supper. (III)

c. There shall be written work schedules and time schedules covering each type of job in the food service department for facilities over 15 beds. These work and time schedules shall be posted or kept in a notebook which is available for use in the food service area. (III)

62.20(2) Nutrition and menu planning.

a. Residents shall be encouraged to the maximum extent possible to participate in meal planning, shopping, and in preparing and serving the meal and cleaning up. The facility shall be responsible for helping residents become knowledgeable of what constitutes a nutritionally adequate diet. (III)

b. Menus shall be planned and served to meet nutritional needs of residents in accordance with the physician's diet orders which shall be renewed yearly. Menus shall be planned and served to include foods and amounts necessary to meet the recommended daily dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. (II) Other foods shall be included to meet energy requirements (calories) to add to the total nutrients and variety of meals. (III)

c. At least three meals or their equivalent shall be made available to each resident daily, consistent with those times normally existing in the community. (II, III)

(1) There shall be no more than a 14-hour span between the substantial evening meal and breakfast. (III)

(2) To the extent medically possible, bedtime nourishments, containing a protein source, shall be offered routinely to all residents. Special nourishments shall be available when ordered by the physician. (II, III)

d. Menus shall include a variety of foods prepared in various ways. The same menus shall not be repeated on the same day of the following week. (III)

e. If modified diets are ordered by the physician, the person responsible for writing the menus shall have completed department-approved training in simple therapeutic diets and a copy of a modified diet manual approved by the department and written within the past five years shall be available in the facility. (II, III)

f. Therapeutic diets shall be served accurately. (II)

g. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing, and serving food. (III)

h. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

i. A file of tested recipes adjusted to the number of people to be fed in the facility shall be maintained. (III)

62.20(3) Dietary storage, food preparation, service.

a. The use of foods from salvaged, damaged, or unlabeled containers is prohibited. (II, III)

b. No perishable food shall be allowed to stand at room temperature any longer than is required to prepare and serve. (II, III)

c. Canning of food is prohibited. The facility may freeze fruits, vegetables, and meats provided strict sanitary procedures are followed and in accordance with recommendations in the "Food Service Manual" revised 1976, U.S. Department of Health, Education, and Welfare, Public Health Service, U.S. Government Printing Office, Washington, D.C. (II)

d. Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a three-day period shall be maintained on the premises. (III)

e. If family-style service is used, all leftover prepared food that has been on the table shall be safely handled. (III)

f. Poisonous compounds shall not be kept in food storage or preparation areas except for a sanitizing agent which shall be kept in a locked cabinet. (II, III)

62.20(4) Sanitation in food preparation area.

a. The facility shall develop and implement policies and procedures to address sanitation, meal preparation and service in accordance with recommendations in the food service sanitation manual pursuant to 62.20(2) "c," and which shall be used as the established, nationally recognized reference for establishing and determining satisfactory compliance with the department's food service and sanitation rules. (III)

b. Residents shall be allowed in the food preparation area in accordance with their IPP. (III)

c. In facilities licensed for over 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)

d. All appliances and work areas shall be kept clean and sanitized. (III)

e. There shall be written procedures established for cleaning all work and serving areas in facilities over 15 beds and a schedule of duties to be performed daily shall be posted in each food area. (III)

f. The food service area shall be located so it will not be used as a passageway by residents, guests, or nonfood service staff in facilities over 15 beds. (III)

g. Dirty linen shall not be carried through the food service area unless it is in sealed, leakproof containers. (III)

h. Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

62.20(5) Hygiene of food service personnel.

a. In the event food service employees are assigned duties outside the dietetic service, these duties shall not interfere with sanitation, safety, or time required for dietetic work assignments. (II, III)

b. Employees shall wear clean, washable uniforms that are not used for duties outside the food service area in facilities over 15 beds. (III)

- c. Hairnets shall be worn by all food service personnel in facilities over 15 beds and effective hair restraints in facilities less than 15 beds. (III)
 - d. Persons handling food shall use correct hand-washing and food-handling techniques as identified in the food service sanitation manual. (III)
 - e. Persons handling dirty dishes shall not handle clean dishes without washing their hands. (III)
- This rule is intended to implement Iowa Code section 135C.14.

481—62.21(135C) Physical facilities and maintenance.

62.21(1) Housekeeping. The facility shall have written procedures for daily and weekly cleaning (III) to include but need not be limited to:

- a. All rooms including furnishings, all corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment or accumulations of refuse. (III)
- b. All resident bedrooms, including furnishings, shall be cleaned and sanitized before use by another resident. (III)
- c. Polishes used on floors shall provide a slip-resistant finish. (III)

62.21(2) Equipment. Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

- a. All facilities shall be provided with clean and sanitary storage for cleaning equipment, supplies, and utensils. In facilities over 15 beds a janitor's closet shall be provided. It shall be equipped with water for filling scrub pails and a janitor's sink for emptying scrub pails. A hallway or corridor shall not be used for storage of equipment. (III)
- b. Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)
- c. All containers for trash shall be watertight, rodent-proof, and have tight-fitting covers and shall be thoroughly cleaned each time a container is emptied. (III)
- d. All wastes shall be properly disposed of in compliance with the local ordinances and state codes. (III)

62.21(3) Bedrooms.

- a. Each resident shall be provided with a bed, substantially constructed and in good repair. Roll-away beds, metal cots, or folding beds are not acceptable. (III)
- b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately 5 inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size. (III)
- c. There shall be a comfortable chair, either a rocking chair or arm chair, per resident bed. The resident's personal wishes shall be considered and documented. (III)
- d. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)
- e. There shall be a bedside table with a drawer and a reading lamp for each resident.
- f. All furnishings and equipment shall be durable, cleanable, and appropriate to their function. (III)
- g. All resident areas shall be decorated, painted, and furnished to provide a homelike atmosphere and in a manner which is age and culture appropriate. (III)
- h. Upholstery materials shall be moisture- and soil-resistant, except on furniture which is provided by the resident and is the property of the resident. (III)
- i. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)
- j. Beds shall not be placed with the side of the bed against a radiator or in close proximity to it unless the radiator is covered to protect the resident from contact with it or from excessive heat. (III)

62.21(4) Bath and toilet facilities. All lavatories shall have nonreusable towels and an available supply of soap. (III)

62.21(5) Dining and living rooms.

- a. Every facility shall have a dining room and a living room easily accessible to all residents. (III)
- b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)
- c. Dining rooms and living rooms shall be available for use by residents at appropriate times to allow social, diversional, individual, and group activities. (III)
- d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 481—subrule 60.6(2) are met. (III)
- e. Living rooms shall be suitably furnished and maintained for the use of residents and their visitors and may be used for recreational activities. (III)
- f. Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

62.21(6) Family and employee accommodations.

- a. The residents' bedrooms shall not be occupied by employees, family members of employees, or family members of the licensee. (III)
- b. In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower is the minimum requirement. (III)
- c. In all health care facilities, if the family or employees live within the facility, living quarters shall be required for the family or employees separate from areas provided for residents. (III)

62.21(7) Animals. Animals shall be allowed within the facility with written approval of the department and under controlled conditions. (III)

62.21(8) Maintenance. Each facility shall establish a maintenance program to ensure continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. In facilities over 15 beds, this program shall be in writing and be available for review by the department. (III)

- a. The buildings, furnishing, and grounds shall be maintained in a clean, orderly condition and be in good repair. (III)
- b. The buildings and grounds shall be kept free of flies, other insects, rodents, and their breeding areas. (III)

62.21(9) Buildings, furnishings, and equipment.

- a. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per employee on duty from 6 p.m. to 6 a.m. (III)
- b. All windows shall be supplied with curtains and shades or drapes which are kept in good repair. (III)
- c. Wherever glass sliding doors or transparent panels are used, they shall be marked conspicuously and decoratively. (III)

62.21(10) Water supply. Every facility shall have an adequate water supply from an approved source. A municipal source of water shall be considered as meeting this requirement. (III) Private sources of water to a facility shall be tested annually and the report submitted with the annual application for license. (III)

- a. A bacterially unsafe source of water shall be grounds for denial, suspension, or revocation of license. (III)
- b. The department may require testing of private sources of water to a facility at its discretion in addition to the annual test. The facility shall supply reports of tests as directed by the department. (III)

This rule is intended to implement Iowa Code section 135C.14.

481—62.22(135C) Care review committee. Each facility shall have a care review committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for care review committees promulgated by the department on aging. (II)

62.22(1) Role of committee in complaint investigations.

- a. The department shall notify the facility's care review committee of a complaint from the public. The department shall not disclose the name of a complainant.

b. The department may refer complaints to the care review committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department on aging. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation of the investigation.

c. When the department investigates a complaint, upon conclusion of its investigation, it shall notify the care review committee and the department on aging of its findings, including any citations and fines issued.

d. Results of all complaint investigations addressed by the care review committee shall be forwarded to the department within ten days of completion of the investigation.

62.22(2) The care review committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

62.22(3) When requested, names, addresses and telephone numbers of family members shall be given to the care review committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the member's name, address or telephone number given to the care review committee.

This rule is intended to implement Iowa Code section 135C.25.

481—62.23(135C) Residents' rights in general.

62.23(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions subrules (62.23(2) to 62.23(22)) and which govern all areas of service provided to staff, residents, their families or legal representatives and shall be available to the public and shall be reviewed annually. (II)

62.23(2) Grievances. Written policies and procedures shall include a method for submitting grievances and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. The written procedure shall ensure protection of the resident from any form of reprisal or intimidation and shall include:

a. An employee or an alternate designated to be responsible for handling grievances and recommendations; (II) and

b. Methods to investigate and assess the validity of a grievance or recommendation, resolve grievances, and take action. (II)

62.23(3) Informed of rights. Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies and be posted in locations accessible to all residents. (II)

a. The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from residents. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

b. Resident's rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are not English-speaking or are deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

c. A statement shall be signed by the resident and legal guardian, if applicable, indicating an understanding of these rights and responsibilities, and the statement shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or legal guardian. (II)

d. All residents, next of kin, or legal guardian shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be used to inform non-English-speaking, deaf or blind residents of changes. (II)

62.23(4) Informed of health condition. Each resident or legal guardian shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated as documented by a physician in the resident's record. (II)

62.23(5) Research. The resident or legal guardian shall make the decision as whether to participate in experimental research and then only upon written informed consent. (II, III)

Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirement of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended to December 1, 1981 (45 CFR 46). (III)

62.23(6) Resident work. Services performed by the resident for the facility shall be in accordance with the IPP. (II)

a. Residents shall not be used to provide a source of labor for the facility against the resident's will. Physician's approval is required for all work programs and must be renewed yearly. (II, III)

b. If the individual program plan requires activities for therapeutic or training reasons, the plan for these activities must be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time-limited and reviewed at least quarterly. (II)

c. A resident engaged in work programs in the RCF/PMI shall be paid wages commensurate with wage and hour regulations for comparable work and productivity. (II)

d. The resident shall have the right to employment options commensurate with training and skills. (II)

62.23(7) Residents performing work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

62.23(8) Encouragement to exercise rights. Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise resident and citizen rights and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

62.23(9) Posting of names. The facility shall post in a prominent area the name, telephone number, and address of the long-term care resident's advocate/ombudsman, survey agency, local law enforcement agency, care review committee members, Iowa Protection and Advocacy Services, Inc., and text of Iowa Code section 135C.46, to provide to residents another course of redress. (II)

62.23(10) Dignity preserved. Each resident shall be treated with consideration, respect, and full recognition of the resident's dignity and individuality, including privacy in treatment and in care of personal needs. (II)

a. Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of the individuality and dignity of human beings. (II)

b. Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping, eating, and times to retire at night and arise in the morning shall be elicited and considered by the facility. The facility shall make every effort to match nonsmokers with other nonsmokers. (II)

c. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

d. Privacy for each person shall be maintained when residents are being taken to the toilet or being bathed and while they are being helped with other types of personal hygiene, except as needed for resident safety or assistance. (II)

e. Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This does not apply under emergency conditions. (II)

62.23(11) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents. Each resident may send and receive personal mail unopened unless prohibited in the IPP which has explicit approval of the resident or legal guardian. (II)

62.23(12) Visiting hours. Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

a. Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- (1) The resident refuses to see the visitor(s). (II)
- (2) The visit would not be in accordance with the IPP. (II)
- (3) The visitor's behavior is unreasonably disruptive to the functioning of the facility.

Reasons for denial of visitation shall be documented in the resident's records. (II)

b. Decisions to restrict a visitor are reevaluated at least quarterly by the QMHP or at the resident's request. (II)

62.23(13) Privacy. Space shall be provided for residents to receive visitors in comfort and privacy. (II)

62.23(14) Telephone calls. Telephones consistent with ANSI standards 42 CFR 405.1134(c) (10-1-86) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

62.23(15) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

62.23(16) Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, QMHP, or facility administrator for refusing permission. (II)

62.23(17) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules; however, residents shall be encouraged to participate in recreational programs. (II)

62.23(18) Resident activities. Each resident may participate in activities of social, religious, and community groups as desired unless contraindicated for reasons documented by the attending physician or qualified mental health professional, as appropriate, in the resident's record. (II)

Residents who wish to meet with or participate in activities of social, religious or community groups in or outside the facility shall be informed, encouraged, and assisted to do so. (II)

62.23(19) Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided use is not otherwise prohibited in these rules. (II)

a. Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a secure location which is convenient to the resident. (II)

b. Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

c. Any personal clothing or possessions retained by the facility for the resident shall be identified and recorded on admission and the record placed on the resident's chart. The facility shall be responsible for secure storage of items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

d. A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

e. A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that

a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

62.23(20) Sharing rooms. Residents, including spouses staying in the same facility, shall be permitted to share a room, if available, if requested by both parties, unless contraindicated in the IPP and when the reasons for denial are documented in the resident's record. (II)

62.23(21) Choice of physician and pharmacy. Each resident shall be permitted free choice of a physician and a pharmacy. The facility may require the pharmacy selected to use a drug distribution system compatible with the system currently used by the facility. (II)

62.23(22) Incompetent residents.

a. Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's legal guardian when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This paragraph is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

b. The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the legal guardian, if any, and acquire a statement indicating an understanding of resident's rights. (II)

62.23(23) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from physical, sexual, mental and verbal abuse, exploitation, and physical injury. (I, II)

62.23(24) Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain the separation until the abuse investigation is completed. (I, II)

62.23(25) Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

This rule is intended to implement Iowa Code sections 135C.14(8) and 135C.24.

481—62.24(135C) County care facilities. In addition to Chapter 62 licensing rules, county care facilities licensed as residential care facilities for persons with mental illness must also comply with department of human services rules, 441—Chapter 37. Violation of any standard established by the department of human services is a class II violation pursuant to 481—56.2(135C).

This rule is intended to implement Iowa Code section 227.4.

481—62.25(135C) Another business or activity in a facility. A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs "a" through "j" of this rule. (I, II, III)

62.25(1) The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a.* Health and safety risks for residents;
- b.* Compatibility of the proposed business or activity with the facility program;

- c. Noise created by the proposed business or activity;
- d. Odors created by the proposed business or activity;
- e. Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- f. Use of the facility's corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- g. Proposed staffing for the business or activity;
- h. Sharing of services and staff between the proposed business or activity and the facility;
- i. Facility layout and design; and
- j. Parking area utilized by the business or activity.

62.25(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

62.25(3) A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 60. (I, II, III)

This rule will become effective July 1, 1992.

481—62.26(135C) Respite care services. Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A facility which chooses to provide respite care services must meet the following requirements related to respite care services and must be licensed as a health care facility.

62.26(1) A facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

62.26(2) Rules regarding involuntary discharge or transfer rights do not apply to residents who are being cared for under a respite care contract.

62.26(3) The facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements for contracts between a health care facility and resident, except the requirements concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons.

62.26(4) Respite care services shall not be provided by a facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 135C.2(6), 135C.4, 135C.6(1) to 135C.6(3), 135C.7, 135C.8, 135C.14, 135C.16(2), 135C.23 to 135C.25, 135C.31, 135C.36, and 227.4.

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CHAPTER 63
RESIDENTIAL CARE FACILITIES FOR THE MENTALLY RETARDED
[Prior to 7/15/87, Health Department[470] Ch 63]

481—63.1(135C) Definitions. For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words “shall” and “must” indicate those standards are mandatory. The use of the words “should” and “could” indicate those standards are recommended.

63.1(1) “*Accommodation*” means the provision of lodging, including sleeping, dining, and living areas.

63.1(2) “*Administrator*” means a person who administers, manages, supervises, and is in general administrative charge of a residential care facility for the mentally retarded, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

63.1(3) “*Alcoholic*” means a person in a state of dependency resulting from excessive or prolonged consumption of alcoholic beverages as defined in Iowa Code section 125.2.

63.1(4) “*Ambulatory*” means a person who immediately and without aid of another, is physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

63.1(5) “*Basement*” means that part of a building where the finish floor is more than 30 inches below the finish grade.

63.1(6) “*Board*” means the regular provision of meals.

63.1(7) “*Communicable disease*” means a disease caused by the presence of virus or microbial agents within a person’s body, which agents may be transmitted either directly or indirectly to other persons.

63.1(8) “*Department*” means the state department of inspections and appeals.

63.1(9) “*Distinct part*” means a clearly identifiable area or section within a residential care facility for the mentally retarded, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

63.1(10) “*Drug addiction*” means a state of dependency, as medically determined, resulting from excessive or prolonged use of drugs as defined in Iowa Code chapter 124.

63.1(11) “*Interdisciplinary team*” means persons drawn from, or representing such of the professions, disciplines, or services required for the care of the resident.

63.1(12) “*Medication*” means any drug including over-the-counter substances ordered and administered under the direction of the physician.

63.1(13) “*Nonambulatory*” means a person who immediately and without the aid of another is not physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

63.1(14) “*Personal care*” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are help in getting in and out of bed, assistance with personal hygiene and bathing, help with dressing and feeding, and supervision over medications which can be self-administered.

63.1(15) “*Program of care*” means all services being provided for a resident in a health care facility.

63.1(16) “*Qualified mental retardation professional*” means a psychologist, physician, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and having one year’s experience working with the mentally retarded.

63.1(17) “*Rate*” means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these regulations.

63.1(18) “*Responsible party*” means the person who signs or cosigns the admission agreement required in 481—63.14(135C) or the resident’s guardian or conservator if one has been appointed. In the event that a resident has neither a guardian, conservator nor person who signed or cosigned the resident’s admission agreement, the term “responsible party” shall include the resident’s sponsoring

agency, e.g., the department of social services, Veterans Administration, religious groups, fraternal organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

63.1(19) “*Restraints*” means the measures taken to control a resident’s physical activity for the resident’s own protection or for the protection of others.

481—63.2(135C) Variances. Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual residential care facility for the mentally retarded. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

63.2(1) To request a variance, the licensee must:

- a. Apply for variance in writing, on a form provided by the department;
- b. Cite the rule or rules from which a variance is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain alternate arrangement or compensating circumstances which justify the variance;
- e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

63.2(2) Upon receipt of a request for variance, the director of the department of inspections and appeals will:

- a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;
- b. If the request meets the above criteria, evaluate the alternate arrangements or compensating circumstances against the requirement of the rules;
- c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;
- d. Consult with the applicant if additional information is required.

63.2(3) Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

481—63.3(135C) Application for licensure.

63.3(1) Initial application and licensing. In order to obtain an initial residential care facility for the mentally retarded license, for a residential care facility for the mentally retarded which is currently licensed, the applicant must:

- a. Meet all of the rules, regulations, and standards contained in 481—Chapters 60 and 63;
- b. Submit a letter of intent and a written résumé of the resident care program and other services provided which reflect the services indicated in individualized programs of care for each resident for departmental review and approval;
- c. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;
- d. Submit a floor plan of each floor of the facility drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which each room will be put and window and door location;
- e. Submit a photograph of the front and side elevation of the facility;
- f. Submit the statutory fee for a residential care facility for the mentally retarded for which licensure application is made;
- g. Comply with all other local statutes and ordinances in existence at the time of licensure;
- h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

63.3(2) In order to obtain an initial residential care facility for the mentally retarded license for a facility not currently licensed as a residential care facility for the mentally retarded, the applicant must:

- a. Meet all of the rules, regulations, and standards contained in 481—Chapters 60 and 63 (exceptions noted in 60.3(2) shall not apply);
- b. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;
- c. Make application at least 30 days prior to the proposed opening date of the facility on forms provided by the department;
- d. Submit a floor plan of each floor of the residential care facility for the mentally retarded, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which the room will be put and window and door locations;
- e. Submit a photograph of the front and side elevation of the residential care facility for the mentally retarded;
- f. Submit the statutory fee for a residential care facility for the mentally retarded;
- g. Comply with all other local statutes and ordinances in existence at the time of licensure;
- h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

63.3(3) Renewal application. In order to obtain a renewal of the residential care facility for the mentally retarded license, the applicant must:

- a. Submit the completed application form 30 days prior to annual license renewal date of residential care facility for the mentally retarded license;
- b. Submit the statutory license fee for a residential care facility for the mentally retarded with the application for renewal;
- c. Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;
- d. Submit appropriate changes in the résumé to reflect any changes in the resident care program and other services.

63.3(4) Deemed status.

a. The department shall recognize, in lieu of its own inspection, the comparable inspection and inspection findings of the Accreditation Council for Service for Mentally Retarded and Other Developmentally Disabled Persons (AC—MR/DD), if the department is given copies of all requested materials relating to the comparable inspection process, is notified of the scheduled comparable inspection not less than 30 days in advance of the inspection, and is given the opportunity to monitor the comparable inspection. The department may verify the findings of 10 percent of the comparable inspections, selected annually on a random basis, in order to ensure compliance with minimum residential care standards established pursuant to this chapter.

b. The above accreditation will be accepted in lieu of the department's yearly licensure inspection for each year of the AC—MR/DD accreditation period up to two years.

63.3(5) Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

This rule is intended to implement Iowa Code sections 135C.6(1) and 135C.9.

481—63.4(135C) General requirements.

63.4(1) The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

63.4(2) The license shall be valid only in the possession of the licensee to whom it is issued.

63.4(3) The posted license shall accurately reflect the current status of the residential care facility for the mentally retarded. (III)

63.4(4) Licenses expire one year after the date of issuance, or as indicated on the license.

63.4(5) Each citation or a copy of each citation issued by the department for a class I or class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons

inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

481—63.5(135C) Notifications required by the department. The department shall be notified:

63.5(1) Within 48 hours, by letter, of any reduction or loss of personal care or dietary staff lasting more than seven days which places the staffing ratio below that required for licensing. No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

63.5(2) Of any proposed change in the residential care facility for the mentally retarded's functional operation or addition or deletion of required services; (III)

63.5(3) Thirty days before addition, alteration, or new construction is begun in the residential care facility for the mentally retarded, or on the premises; (III)

63.5(4) Thirty days in advance of closure of the residential care facility for the mentally retarded; (III)

63.5(5) Within two weeks of any change in administrator; (III)

63.5(6) When any change in the category of license is sought; (III)

63.5(7) Prior to the purchase, transfer, assignment, or lease of a residential care facility for the mentally retarded the licensee shall:

a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)

b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)

c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's residential care facility for the mentally retarded to the named prospective purchaser, transferee, assignee, or lessee; (III)

63.5(8) Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of a residential care facility for the mentally retarded, the department shall upon request, send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

481—63.6(135C) Witness fees. Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

481—63.7(135C) Licenses for distinct parts.

63.7(1) Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

63.7(2) The following requirements shall be met for a separate licensing of a distinct part:

a. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)

b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

c. A distinct part must be operationally and financially feasible;

d. A separate staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)

e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry, and dietary in common with each other.

481—63.8(135C) Administrator. Each residential care facility for the mentally retarded shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. (III)

63.8(1) The administrator shall be at least 18 years of age and shall have a high school diploma or equivalent. (III) In addition this person shall meet at least one of the following conditions:

a. Be a licensed nursing home administrator who is also a qualified mental retardation professional; (III) or

b. Be a qualified mental retardation professional with at least one year of experience in an administrative capacity in a health care facility; (III) or

c. Have completed a one-year educational training program approved by the department for residential care facility for the mentally retarded. (III)

63.8(2) The administrator may act as an administrator for not more than two residential care facilities for the mentally retarded. (II)

a. The distance between the two facilities shall be no greater than 50 miles. (II)

b. The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)

c. The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

63.8(3) The licensee may be the approved administrator providing the licensee meets the requirements as set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

63.8(4) A provisional administrator may be appointed on a temporary basis by the residential care facility for the mentally retarded licensee to assume the administrative responsibilities for a residential care facility for the mentally retarded for a period not to exceed six months when, through no fault of its own, the home has lost its administrator and has not been able to replace the administrator, provided the department has been notified prior to the date of the administrator's appointment. (III)

63.8(5) In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

a. Be knowledgeable of the operation of the facility; (III)

b. Have access to records concerned with the operation of the facility; (III)

c. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)

d. Be at least 18 years of age; (III)

e. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)

f. Have had training to carry out assignments and take care of emergencies and sudden illnesses of residents. (III)

63.8(6) The licensee shall:

a. Assume the responsibility for the overall operation of the residential care facility for the mentally retarded; (III)

b. Be responsible for compliance with all applicable laws and with the rules of the department; (III)

c. Establish written policies, which shall be available for review, for the operation of the residential care facility for the mentally retarded. (III)

63.8(7) The administrator shall:

a. Be responsible for the selection and direction of competent personnel to provide services for the resident care program; (III)

b. Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)

c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)

d. Make available the residential care facility for the mentally retarded payroll records for departmental review as needed. (III)

481—63.9(135C) General policies.

63.9(1) There shall be written personnel policies in facilities of more than 15 beds to include hours of work, and attendance at educational programs. (III)

63.9(2) There shall be a written job description developed for each category of worker in facilities. The job description shall include title of job, job summary, age range, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

63.9(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

- a. Employees shall have a physical examination before employment. (I, II, III)
- b. Employees shall have a physical examination at least every four years. (I, II, III)
- c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

63.9(4) Health certificates for all employees shall be available for review. (III)

63.9(5) Rescinded IAB 10/19/88, effective 11/23/88.

63.9(6) There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident which includes the individual to be contacted in case of emergency. (III)

63.9(7) The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

63.9(8) The residential care facility for the mentally retarded shall have established policies concerning the control, investigation, and prevention of infections within the facility. (III)

63.9(9) Each facility licensed as a residential care facility for the mentally retarded shall provide an organized continuous 24-hour program of care commensurate with the needs of the residents of the home and under the direction of an administrator whose combined training and supervisory experience is such as to ensure adequate and competent care. (III)

63.9(10) Each facility shall have a written and implemented infection control program addressing the following:

- a. Techniques for hand washing consistent with Guidelines for Handwashing and Hospital Control, 1985, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923404; (I, II, III)
- b. Techniques for handling of blood, body fluids, and body wastes consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)
- c. Dressings, soaks, or packs; (I, II, III)
- d. Infection identification; (I, II, III)
- e. Resident care procedures to be used when there is an infection present consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)
- f. Sanitation techniques for resident care equipment; (I, II, III)
- g. Techniques for sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags; (I, II, III)
- h. Techniques for use and disposal of needles, syringes, and other sharp instruments consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

CDC Guidelines may be obtained from the U.S. Department of Commerce, Technology Administration, National Technical Information Service, 5285 Port Royal Rd., Springfield, Virginia 22161 (1-800-553-6847).

63.9(11) Aseptic techniques. If a resident needs any of the treatments or devices on the list below, written and implemented procedures regarding aseptic techniques shall be followed.

- a. Intravenous or central line catheter consistent with Guideline for Prevention of Intravascular Device Related Infections, Centers for Disease Control, U.S. Department of Health and Human Services, PB97-130074, (I, II, III)
- b. Urinary catheter, (I, II, III)
- c. Respiratory suction, oxygen or humidification, (I, II, III)
- d. Decubitus care, (I, II, III)

- e. Tracheostomy, (I, II, III)
- f. Nasogastric or gastrostomy tubes, (I, II, III)
- g. Sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags. (I, II, III)

63.9(12) Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

[ARC 0663C, IAB 4/3/13, effective 5/8/13]

481—63.10 Rescinded, effective 7/14/82.

481—63.11(135C) Personnel.

63.11(1) *General qualifications.*

a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a residential care facility for the mentally retarded. (II)

b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a residential care facility for the mentally retarded. (II)

c. No person shall be allowed to provide services in a facility if the person has a disease:

- (1) Which is transmissible through required workplace contact, (I, II, III)
- (2) Which presents a significant risk of infecting others, (I, II, III)
- (3) Which presents a substantial possibility of harming others, and (I, II, III)
- (4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guidelines for Infection Control in Hospital Personnel, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923402 to determine (1), (2), (3) and (4).

d. Reserved.

e. Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

63.11(2) *Supervision and staffing.*

a. The department shall establish on an individual facility basis the numbers and qualifications of the staff required in a residential care facility for the mentally retarded, using as its criteria the services being offered as indicated on the résumé program of care and, as required for individual care plans, the needs of the resident. (II, III)

b. Personnel in a residential care facility for the mentally retarded shall provide 24-hour coverage for residential care services for the mentally retarded. Personnel shall be up and dressed at all times in facilities over 15 beds. In facilities with 15 or less beds, personnel shall be up and dressed when residents are awake. (II, III)

c. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. (II, III)

d. Physician's orders shall be implemented by qualified personnel. (II, III)

63.11(3) *Personnel histories.*

a. Each health care facility shall submit a form specified by the department of public safety to the department of public safety, and receive the results of a criminal history check and dependent adult abuse record check before any person is employed in a health care facility. The health care facility may submit a form specified by the department of human services to the department of human services to request a child abuse history check. For the purposes of this subrule, "employed in a facility" shall be defined as any individual who is paid, either by the health care facility or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors), to provide direct or indirect treatment or services to residents in a health care facility. 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 requirements of this subrule are individuals such as

building contractors, repair workers or others who are in a facility for a very limited purpose, are not in the facility on a regular basis, and who do not provide any treatment or services to the residents of the health care facility. (I, II, III)

b. A person who has a criminal record or founded dependent adult abuse report cannot be employed in a health care facility unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse report does not merit prohibition from employment. (I, II, III)

c. Each health care facility shall ask each person seeking employment in a facility “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of crime in this state or any other state?” The person shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The person shall indicate, by signature, that the person has been informed that the record checks will be conducted. (I, II, III)

d. If a person has a record of founded child abuse in Iowa or any other state, the person shall not be employed in a health care facility unless the department of human services has evaluated the crime or founded report and concluded that the report does not merit prohibition of employment. (I, II, III)

e. Proof of dependent adult abuse and criminal history checks may be kept in files maintained by the temporary employee agencies and contractors. Facilities may require temporary agencies and contractors to provide a copy of the results of the dependent adult abuse and criminal history checks. (I, II, III)

481—63.12(135C) Resident care and personal services.

63.12(1) Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

63.12(2) Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

63.12(3) Residents shall have clean clothing as needed to present a neat appearance, be free of odors, and to be comfortable. Clothing shall be appropriate to their activities and to the weather. (III)

63.12(4) Rescinded, effective 7/14/82.

63.12(5) Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

63.12(6) Residents shall not be required to pass through another’s bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

63.12(7) Rescinded, effective 7/14/82.

63.12(8) Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

63.12(9) Residents shall be required to bathe at least twice a week. (II, III)

481—63.13(135C) Admission, transfer, and discharge.

63.13(1) *General admission policies.*

a. No resident shall be admitted or retained in a residential care facility for the mentally retarded who is in need of greater services than the facility can provide. (II, III)

b. No residential care facility for the mentally retarded shall admit more residents than the number of beds for which it is licensed. (II, III)

c. There shall be no more beds erected than is stipulated on the license. (II, III)

d. There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

e. The admission of a resident to a residential care facility for the mentally retarded shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident’s legal representative. (III)

f. The admission of a resident shall not grant the residential care facility for the mentally retarded the authority or responsibility to manage the personal affairs of the resident except as may be necessary

for the safety of the resident and safe and orderly management of the residential care facility for the mentally retarded as required by these rules. (III)

g. A residential care facility for the mentally retarded shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

h. Rescinded, effective 7/14/82.

i. Funds or properties received by the residential care facility for the mentally retarded, belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

j. Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

k. No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity. (III)

l. Upon the verified petition of the county board of supervisors, the district court may appoint the administrator of a county care facility as conservator or guardian or both of a resident of such county care facility. Such administrator shall serve as conservator or guardian or both without fee. The administrator may establish either separate or common bank accounts for cash funds of such resident wards. (III)

63.13(2) Discharge or transfer.

a. Prior notification shall be made to the next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

b. Proper arrangements shall be made by the residential care facility for the mentally retarded for the welfare of the resident prior to transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

c. The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such transfer or discharge. (II, III)

d. Advance notification by telephone will be made to the receiving facility prior to the transfer of any resident. (III)

e. When a resident is transferred or discharged, the appropriate record as set forth in 63.17(1) of these rules will accompany the resident. (II, III)

f. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

481—63.14(135C) Contracts. Each party shall receive a copy of the signed contract. Each contract for residents shall:

63.14(1) State the base rate or scale per day or per month, the services included, and the method of payment; (III)

63.14(2) Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. (III) Furthermore, the contract shall:

a. Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in subrule 63.14(2); (III)

b. State the method of payment of additional charges; (III)

c. Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

d. State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc. (III)

63.14(3) Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on a preadmission evaluation assessment which is determined in consultation with the administrator; (III)

63.14(4) Include the total fee to be charged initially to the resident; (III)

63.14(5) State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

a. Written notification to the resident or responsible party, when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to effective date of such changes; (III)

b. Notification to the resident or responsible party, when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)

63.14(6) State the terms of agreement in regard to refund of all advance payments in the event of transfer, death, voluntary or involuntary discharge; (III)

63.14(7) State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party:

a. The facility shall ask the resident or responsible party if they want the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented; (II)

b. The facility shall reserve the bed when requested for as long as the resident can ensure payment in accordance with the contract; (II)

63.14(8) State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

63.14(9) State the conditions of voluntary discharge or transfer; (III)

63.14(10) Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter. (III)

481—63.15(135C) Physical examinations.

63.15(1) Each resident in a residential care facility for the mentally retarded shall have a designated licensed physician, who may be called when needed. (III)

63.15(2) Each resident admitted to a residential care facility for the mentally retarded shall have had a physical examination prior to admission. (II, III)

a. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be a part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician, shall be a part of the resident's record. (II, III)

b. The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, physical examination, diagnosis, statement of chief complaints, and results of any diagnostic procedures. (II, III)

c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (II, III)

63.15(3) Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

63.15(4) Rescinded, effective 7/14/82.

63.15(5) The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

63.15(6) Each resident shall be visited by or shall visit the resident's physician at least annually. The year period shall be measured from the date of admission and is not to include preadmission physicals. Any required physician task or visit in a residential care facility for the mentally retarded may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician assistant who is working in collaboration with the physician. (III)

63.15(7) Residents shall be admitted to a residential care facility for the mentally retarded only on a written order signed by a physician certifying that the individual being admitted requires no more than personal care and supervision but does not require nursing care. (III)

This rule is intended to implement Iowa Code section 135C.23(2).
[ARC 0663C, IAB 4/3/13, effective 5/8/13]

481—63.16(135C) Dental services.

63.16(1) The residential care facility for the mentally retarded personnel shall assist residents to obtain regular and emergency dental services. (III)

63.16(2) Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)

63.16(3) Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)

63.16(4) All dental reports or progress notes shall be included in the clinical record. (III)

63.16(5) Personal care staff shall assist the resident in carrying out dentist's recommendations. (III)

63.16(6) Dentists shall be asked to participate in the in-service program of the facility. (III)

481—63.17(135C) Records.

63.17(1) *Resident record.* The licensee shall keep a permanent record on all residents admitted to a residential care facility for the mentally retarded with all entries current, dated, and signed. (III) The record shall include:

- a. Name and previous address of resident; (III)
- b. Birth date, sex, and marital status of resident; (III)
- c. Church affiliation; (III)
- d. Physician's name, telephone number, and address; (III)
- e. Dentist's name, telephone number, and address; (III)
- f. Name, address, and telephone number of next of kin or legal representative; (III)
- g. Name, address, and telephone number of person to be notified in case of emergency; (III)
- h. Mortician's name, telephone number, and address; (III)
- i. Pharmacist's name, telephone number, and address; (III)
- j. Physical examination and medical history; (III)
- k. Certification by the physician that the resident requires no more than personal care and supervision, but does not require nursing care; (III)
- l. Physician's orders for medication, treatment, and diet in writing and signed by the physician; (III)
- m. A notation of yearly or other visits to physician or other professional services; (III)
- n. Any change in the resident's condition; (II, III)
- o. If the physician has certified that the resident is capable of taking prescribed medications, the resident shall be required to keep the administrator advised of current medications, treatments, and diet. The administrator shall keep a listing of medication, treatments, and diet prescribed by the physician for each resident; (III)
- p. If the physician has certified that the resident is not capable of taking prescribed medication, it must be administered by a qualified person of the facility. A qualified person shall be defined as either a registered or licensed practical nurse or an individual who has completed the state-approved training course in medication administration; (II)
- q. Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication; (II, III)

- r. A notation describing condition on admission, transfer, and discharge; (III)
- s. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)
- t. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)
- u. Disposition of valuables. (III)

63.17(2) Incident record.

- a. Each residential care facility for the mentally retarded shall maintain an incident record report and shall have available incident report forms. (III)
- b. Report of incidents shall be in detail on a printed incident report form. (III)
- c. The person in charge at the time of the incident shall oversee the preparation and sign the incident report. (III)
- d. The report shall cover all accidents where there is apparent injury or where hidden injury may have occurred. (III)
- e. The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)
- f. A copy of the incident report shall be kept on file in the facility. (III)

63.17(3) Retention of records.

- a. Records shall be retained in the facility for five years following termination of services. (III)
- b. Records shall be retained within the facility upon change of ownership. (III)
- c. Rescinded, effective 7/14/82.
- d. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

63.17(4) Reports to the department. The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

63.17(5) Personnel record.

- a. An employment record shall be kept for each employee consisting of the following information: name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home, date and reason for discharge or resignation. (III)
- b. The personnel records shall be made available for review upon request by the department. (III)

481—63.18(135C) Drugs.

63.18(1) Drug storage.

- a. Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in their bedroom but locked storage must be provided. (III)
- b. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:
 - (1) A cabinet with a lock shall be provided which can be used for storage of drugs, solutions, and prescriptions; (III)
 - (2) A bathroom shall not be used for drug storage; (III)
 - (3) The drug storage cabinet shall be kept locked; (III)
 - (4) Schedule II drugs, as defined by Iowa Code chapter 124, shall be kept in a locked box within the locked medication cabinet; (II)
 - (5) The medicine cabinet key shall be in the possession of the employee charged with the responsibility of administering medications; (II, III)
 - (6) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items; (III)
 - (7) Drugs for external use shall be stored separately from drugs for internal use; (III)

(8) All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons; (I, II)

(9) The drug cabinet shall have a work counter, both the counter and cabinet shall be well-lighted; (III)

(10) Running water shall be available in the room in which the medicine cabinet is located or in an adjacent room; (III)

(11) Inspection of drug storage condition shall be made by the administrator and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician's order, and drugs improperly stored. (III)

c. Bulk supplies of prescription drugs shall not be kept in a residential care facility for the mentally retarded unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist. (III)

63.18(2) Drug safeguards.

a. All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III)

b. Medication containers having soiled, damaged, illegible or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

c. The medications of each resident shall be kept or stored in the originally received containers. (II, III)

d. When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

e. Unused prescription drugs prescribed for residents who have died shall be destroyed by the person in charge with a witness and notation made on the resident's record, or, if a unit dose system is used, such drugs shall be returned to the supplying pharmacist. (III)

f. Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

g. No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

h. Instructions shall be requested of the Iowa board of pharmacy examiners concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

i. There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by the responsible person with a witness and notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy examiners. (II, III)

j. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The personal physician of the resident, in conjunction with the pharmacist, shall institute these policies and provide procedures for review and endorsement. (II, III)

k. No resident shall be allowed to keep in the resident's possession any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

l. No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

m. Each facility shall establish a policy cooperating with a licensed pharmacist to govern distributing prescribed medication to residents who are on leave from a facility. (III)

(1) Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 63.18(2)“a,” non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident’s name, the facility, the medication, its strength, dose, and time of administration.

(2) Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners.

(3) Medication distributed as above may be issued only by facility personnel responsible for administering medication.

63.18(3) Drug administration.

a. A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

b. The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

c. This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

d. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved residential aide course, nurse aide course, nurse aide training and testing program or nurse aide competency examination;

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

e. A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program’s pharmacology or clinical instructor indicating the individual is competent in medication administration.

f. In an RCF/MR facility licensed for 15 or fewer beds, a person who has successfully completed a state-approved medication manager course may administer medications.

g. A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph “d” of this subrule do not apply to this individual.

h. Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day they are administered, (II) unless the unit dose system is used.

i. Injectable medications shall be administered by a qualified nurse or physician.

j. Residents certified by their physician as capable of injecting their own insulin may do so. Insulin may be administered pursuant to “i” above or as otherwise authorized by the resident’s physician. Authorization by the physician shall:

- (1) Be in writing,
- (2) Be maintained in the resident's record,
- (3) Be renewed quarterly,
- (4) Include the name of the individual authorized to administer the insulin,
- (5) Include documentation by the physician that the authorized person is qualified to administer insulin to that resident.

k. An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

481—63.19(135C) Dietary.

63.19(1) *Dietary staffing.*

a. In facilities licensed for over 15 beds, persons in charge of meal planning and food preparation shall complete the home study course on sanitation and food preparation offered by the department. (III)

b. In facilities licensed for over 15 beds, food service personnel shall be on duty during a 12-hour span extending from the preparation of breakfast through supper. (III)

c. There shall be written work schedules and time schedules covering each type of job in the food service department. These work and time schedules shall be posted or kept in a notebook which is available for use in the food service area in facilities over 15 beds. (III)

63.19(2) *Nutrition and menu planning.*

a. Menus shall be planned and followed to meet nutritional needs of residents in accordance with the physician's orders. (II)

b. Menus shall be planned and served to include foods and amounts necessary to meet the recommended daily dietary allowances of the food and nutrition board of the National Research Council, National Academy of Sciences. (II) Recommended daily dietary allowances are:

- (1) Milk—two or more cups served as beverage or used in cooking;
- (2) Meat group—two or more servings of meat, fish, poultry, eggs, cheese or equivalent; at least four to five ounces edible portion per day;
- (3) Vegetable and fruit group—four or more servings (two cups). This shall include a citrus fruit or other fruit and vegetable important for vitamin C daily, a dark green or deep yellow vegetable for vitamin A at least every other day, and other fruits and vegetables, including potatoes;
- (4) Bread and cereal group—four or more servings of whole-grain, enriched or restored;
- (5) Foods other than those listed will usually be included to meet daily energy requirements (calories) to add to the total nutrients and variety of meals.

c. At least three meals or their equivalent shall be served daily, at regular hours. (II)

(1) There shall be no more than a 14-hour span between substantial evening meal and breakfast. (II, III)

(2) To the extent medically possible, bedtime nourishments shall be offered routinely to all residents. Special nourishments shall be available when ordered by physician. (II, III)

d. Menus shall include a variety of foods prepared in various ways. The same menu shall not be repeated on the same day of the following week. (III)

e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing, and serving food. (III)

f. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

g. A file of tested recipes adjusted to the number of people to be fed in the facility shall be maintained. (III)

63.19(3) *Dietary storage, food preparation, and service.*

a. All food and drink shall be clean, wholesome, free from spoilage, and safe for human consumption. (II, III)

b. The use of food from salvaged, damaged, or unlabeled containers shall be prohibited. (III)

c. All perishable or potentially hazardous food shall be stored at safe temperatures of 45°F (7°C) or below, or 140°F (60°C) or above. (III)

d. No perishable food shall be allowed to stand at room temperature any longer than is required to prepare and serve. (III)

e. Supplies of staple foods for a minimum of a one-week period and or perishable foods for a minimum of a two-day period shall be maintained on the premises. Minimum food portion requirements for a low-cost plan shall conform to information supplied by the nutrition section of the department of health. (II, III)

f. Table service shall be attractive. Dishes shall be free of cracks, chips, and stains. (III)

g. If family-style service is used, all leftover prepared food that has been on the table shall be properly handled. (III)

h. Poisonous compounds shall not be kept in food storage or preparation areas. (II)

63.19(4) Sanitation in food preparation area.

a. "Food Service Sanitation Manual," revised 1976, U.S. Department of Health, Education, and Welfare, Public Health Service, U.S. Government Printing Office, Washington, D.C., shall be used as the established, nationally recognized reference for establishing and determining satisfactory compliance with food service sanitation.

b. Residents shall not be allowed in the food preparation area, unless indicated in their individualized care plans. (III)

c. In facilities licensed for over 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)

d. All foods, while being stored, prepared, displayed, served, or transported shall be protected against contamination from dust, flies, rodents, and other vermin. (II, III)

e. Food shall be protected from unclean utensils and worn surfaces, unnecessary handling, coughs and sneezes, flooding, drainage, and overhead leakage. (II, III)

f. All appliances and work areas shall be kept clean. (III)

g. There shall be written procedures established for cleaning all work and serving areas in facilities over 15 beds. (III)

h. A schedule for duties to be performed daily shall be posted in each food area. (III)

i. All cooking stoves in facilities of 15 or more beds shall be provided with a properly sized exhaust system and hood to eliminate excess heat, moisture, and odors from the kitchen. (III)

j. Spillage and breakage shall be cleaned up immediately. (III)

k. All garbage not mechanically disposed of shall be kept in nonabsorbent, cleanable containers pending disposal. All filled containers shall be covered and stored in a sanitary manner. (III)

l. The food service area shall be located so it will not be used as a passageway by residents, guests, or nonfood service staff. (III)

m. The walls, ceilings, and floors of all rooms in which food is prepared and served shall be in good repair, smooth, washable, and shall be kept clean. (III)

n. There shall be no washing, ironing, sorting, or folding of laundry in the food service area. Dirty linen shall not be carried through the food service area unless it is in sealed, leakproof containers. (III)

o. Ice shall be stored and handled in such a manner as to prevent contamination. Ice scoops should be sanitized daily and kept in a clean container. (III)

p. There shall be no animals or birds in the food preparation area. (III)

q. No dishes or cooking utensils shall be towel dried. (III)

r. In facilities of over 15 beds directions for the dishwashing procedure shall be posted and available to all kitchen personnel. (III)

s. If there is a dishwashing machine, it must provide a wash temperature of 140°F (60°C) to 160°F (71°C) and a rinse temperature of 170°F (70°C) to 180°F (82°C). (III)

t. The washing and sanitizing of dishes and utensils shall meet approved sanitation procedures and practices. In facilities of 15 or more beds, a mechanical dishwashing machine or three-compartment sink shall be used for washing dishes; a booster heater for the third compartment or sanitizing agent shall be used. (III)

u. All dishes, silverware, and cooking utensils shall be stored above the floor in a sanitary manner, in a clean, dry place protected from flies, splashes, dust, and other contaminants. (III)

v. Procedures for washing and handling dishes shall be followed in order to protect the welfare of the residents and employees. Persons handling dirty dishes shall not handle clean dishes without washing their hands. (III)

w. Dishes, silverware, and cooking utensils shall be properly cleaned by prerinsing or scraping, washing, sanitizing, and air-drying. (III)

63.19(5) Hygiene of food service personnel.

a. Food service personnel shall be free of communicable diseases and practice hygienic food-handling techniques. In the event food service employees are assigned duties outside the dietetic service, these duties shall not interfere with sanitation, safety, or time required for dietetic work assignments. Personnel recovering from a diagnosed intestinal infection shall submit a report from their physician showing freedom from infection before returning to work in the food service department. (II, III)

b. Staff employees who are full-time food service personnel shall wear clean, washable uniforms that are not used for duties outside the food service area. In all facilities, employees shall wear clean, washable clothing when in the food service area. (III)

c. Hairnets shall be worn by all staff food service personnel. Total enclosure of facial hair shall be provided for staff personnel. (III)

d. Clean aprons and hairnets shall be available for use by other personnel in emergency situations. (III)

e. Persons handling food shall be knowledgeable of good hand-washing techniques. A hand-wash sink shall be provided in or adjacent to the food service area. Continuous on-the-job training on sanitation shall be encouraged. (III)

f. The use of tobacco shall be prohibited in the kitchen. (III)

63.19(6) Food and drink. All food and drink consumed within the facility shall be clean and wholesome and comply with local ordinances and applicable provisions of state and federal laws. (II, III)

481—63.20(135C) Orientation program.

63.20(1) The administrator or designee shall be responsible for developing a written, organized orientation program for all residents. (III)

63.20(2) The program shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the medical or health care, recovery, and rehabilitation of the individual. (III)

481—63.21(135C) Individualized program of care.

63.21(1) The individualized program of care, including specific goals and regular evaluation of progress, shall incorporate the social services, psychological, educational activities, and medical needs of the residents, and shall be designed by an interdisciplinary team. (II)

63.21(2) Each residential care facility for the mentally retarded shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

a. The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

b. The program shall include individual goals for each resident. (III)

c. The activity program shall include both group and individual activities. (III)

d. Residents shall be encouraged, but not forced, to participate in the activity program. (III)

63.21(3) Coordination of activities program.

a. Each residential care facility for the mentally retarded with over 15 beds shall employ a person to direct the activities program. (III)

¹b. ²Staffing for the activity program shall be provided on the minimum basis of 45 minutes per licensed bed per week. (II, III)

c. The activity coordinator shall have completed the activity coordinators' orientation course offered through the department within six months of employment or have comparable training and experience as approved by the department. (III)

d. The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

e. There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

63.21(4) Duties of activity coordinator. The activity coordinator shall:

a. Have access to all residents' records excluding financial records; (III)

b. Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)

c. Keep all necessary records including:

(1) Attendance; (III)

(2) Individual resident progress notes recorded at regular intervals (at least every three months).

(III)

(3) Monthly calendars, prepared in advance. (III)

d. Coordinate the activity program with all other services in the facility; (III)

e. Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

63.21(5) Supplies, equipment, and storage.

a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III) These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc.

b. Storage shall be provided for recreational equipment and supplies. (III)

c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

¹ Emergency, pursuant to Iowa Code section 17A.5(2)"b"(2).

² Objection filed 2/14/79; see Objection following 481—Ch 57.

481—63.22(135C) Care review committee. Each facility shall have a care review committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for care review committees promulgated by the department on aging. (II)

63.22(1) Role of committee in complaint investigations.

a. The department shall notify the facility's care review committee of a complaint from the public. The department shall not disclose the name of a complainant.

b. The department may refer complaints to the care review committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department on aging. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation of the investigation.

c. When the department investigates a complaint, upon conclusion of its investigation, it shall notify the care review committee and the department on aging of its findings, including any citations and fines issued.

d. Results of all complaint investigations addressed by the care review committee shall be forwarded to the department within ten days of completion of the investigation.

63.22(2) The care review committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

63.22(3) When requested, names, addresses and telephone numbers of family members shall be given to the care review committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the member's name, address or telephone number given to the care review committee.

481—63.23(135C) Safety. The licensee of a residential care facility for the mentally retarded shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

63.23(1) Fire safety.

a. All residential care facilities for the mentally retarded shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

b. The size and condition of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

63.23(2) Safety duties of administrator. The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency which shall be rehearsed at least quarterly. (III)

a. The plan shall be available for review upon request. (III)

b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

63.23(3) Resident safety.

a. Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when the resident is under direct supervision. (II, III)

b. Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)

c. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

d. Smoking shall be permitted only in designated areas. (II, III)

e. Residents shall receive adequate supervision to ensure against hazards from themselves, others, or elements in the environment. (II, III)

63.23(4) Restraints.

a. Residents shall not be kept behind locked doors.

b. Temporary seclusion of residents shall be used only in an emergency to prevent injury to the resident or to others pending transfer to appropriate placements.

c. A divided door equipped with a securing device that may be readily opened by personnel shall be considered an appropriate means of temporarily confining a resident in the resident's room.

d. Divided doors shall be of such type that when the upper half is closed the lower section shall close.

481—63.24(135C) Housekeeping.

63.24(1) Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

63.24(2) Each resident unit shall be cleaned on a routine schedule. (III)

63.24(3) All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

63.24(4) A hallway or corridor shall not be used for storage of equipment. (III)

63.24(5) All odors shall be kept under control by cleanliness and proper ventilation. (III)

63.24(6) Clothing worn by personnel shall be clean and washable. (III)

63.24(7) Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

63.24(8) All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

63.24(9) Polishes used on floors shall provide a nonslip finish. (III)

63.24(10) Throw or scatter rugs shall not be permitted. (III)

63.24(11) Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

63.24(12) Cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials shall not be accessible to residents except as indicated in individualized programs of care. (II, III)

63.24(13) Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

481—63.25(135C) Maintenance.

63.25(1) Each facility shall establish a maintenance program to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. In facilities over 15 beds, this program shall be established in writing and available for review by the department. (III)

63.25(2) The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

63.25(3) Draperies and furniture shall be clean and in good repair. (III)

63.25(4) Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

63.25(5) The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the National Electrical Code. (III)

63.25(6) All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

63.25(7) Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. (III)

63.25(8) The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

63.25(9) The facility shall be kept free of flies, other insects, and rodents. (III)

63.25(10) Janitor closet.

a. Facilities shall be provided with storage for cleaning equipment, supplies, and utensils. (III)

b. Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

c. In facilities licensed for over 15 beds, a janitor's closet shall be provided. It shall be equipped with water for filling scrub pails and janitor's sink for emptying scrub pails. (III)

481—63.26(135C) Laundry.

63.26(1) All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

63.26(2) Except for related activities, the laundry room shall not be used for other purposes. (III)

63.26(3) Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

63.26(4) Residents' personal laundry shall be marked with an identification. (III)

63.26(5) Bed linens, towels, washcloths, and residents' clothing shall be clean and stain-free. (III)

63.26(6) If laundry is done in the facility, the following shall be provided:

a. A clean, dry, well-lighted area to accommodate a washer and dryer of adequate size to serve the needs of the facility. (III)

b. In facilities of over 15 beds, the laundry room shall be divided into separate areas, one for sorting soiled linen and one for sorting and folding clean linen. (III)

481—63.27(135C) Garbage and waste disposal.

63.27(1) All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

63.27(2) All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

63.27(3) All containers shall be thoroughly cleaned each time the containers are emptied. (III)

63.27(4) All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

63.27(5) Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

481—63.28(135C) Buildings, furnishings, and equipment.**63.28(1) Buildings—general requirements.**

a. For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than 7 feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

b. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

c. All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

d. Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

e. Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

f. All fans located within 7 feet of the floor shall be protected by screen guards of not more than ¼-inch mesh. (III)

g. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

h. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

i. No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates, except closets used for the storage of resident's clothing. (III)

j. All stairways in resident-occupied areas shall have substantial handrails on both sides. (III)

k. Each stairway shall have protective barriers. (III)

l. Screens of 16 mesh per square inch shall be provided at all hold-open openings. (III)

m. Screen doors shall swing outward and be self-closing. At the discretion of the state fire marshal, screens for fire doors may swing in. (III)

n. All resident rooms shall have a door. (III)

o. All rooms in resident-occupied areas shall have general lighting switched at the entrance to each room. (III)

63.28(2) Furnishings and equipment.

a. All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a homelike atmosphere. (III)

c. Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

d. Night lights may be required in corridors, at stairways, attendant's stations and resident's bedrooms, and hazardous areas with no less than 1 foot-candle throughout the area at all times. (III)

63.28(3) Dining and living rooms.

a. Every facility over 15 beds shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 63.28(3) "e" of the rules are met. (III)

e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment. (III)

f. Living rooms.

(1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)

(2) Living rooms shall be suitably furnished. (III)

(3) When space is provided to be used only for activities and recreational purposes, the area shall be at least 15 square feet per licensed bed. At least 50 percent of the required area must be in one room. (III)

g. Dining rooms.

(1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

(2) When space is provided to be used only for dining, the area shall total at least 15 square feet per licensed bed. (III)

63.28(4) Bedrooms.

a. Each resident shall be provided with a standard, single, or twin bed, substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. (III)

b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; clean, comfortable pillows of average bed size. (III)

c. Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)

d. There shall be a comfortable bedside chair per resident bed. The resident's personal wishes shall be considered. (III)

e. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

f. Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)

g. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

h. There shall be a wardrobe or closet in each resident's room. Minimum clear dimensions shall be 1 foot 10 inches deep by 1 foot 8 inches wide with full hanging space and provide a clothes rod and shelf. In a multiple bedroom, closet or wardrobe space shall be assigned each resident sufficient for the resident's needs. (III)

i. Beds shall not be placed with the head of the bed in front of a window or radiator. (III)

j. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)

k. Reading lamps shall be provided each resident in the resident's room. (III)

l. Each room shall have sufficient accessible mirrors to serve residents' needs. (III)

m. Usable floor space of a room shall be no less than 8 feet in any major dimension. (III)

n. Bedrooms shall have a minimum of 80 square feet of usable floor space per bed. (III)

- o.* There shall be no more than four residents per room. (III)
- p.* Each resident room shall be provided with light and ventilation by means of a window or windows with an area equal to one-eighth of the total floor area. The windows shall be openable. (III)

63.28(5) Bath and toilet facilities.

- a.* Provision shall be made for bars to hold individual towels and washcloths. (III)
- b.* In facilities of over 15 beds all lavatories shall have paper towel dispensers and an available supply of soap. (III)
- c.* Minimum numbers of toilet and bath facilities shall be one lavatory, one toilet for each five residents, and one tub or shower for each ten residents or fraction thereof. (III)
- d.* There shall be a minimum of one bathroom with tub or shower, toilet stool and lavatory on each floor in multistory buildings for facilities licensed for over 15 beds. Separate toilets for the sexes shall be provided. (III)
- e.* Grab bars shall be provided at all toilet stools, tubs, and showers. Grab bars, accessories, and anchorage shall have sufficient strength to sustain a deadweight of 250 pounds for five minutes. (III)
- f.* Each toilet room shall have a door. (III)
- g.* All toilet, bath, and shower facilities shall be supplied with adequate safety devices appropriate to the needs of the individual residents. Raised toilet seats shall be available for residents who are aged or infirm. (III)
- h.* Toilet and bath facilities shall have an aggregate outside window area of at least 4 square feet. Facilities having a system of mechanical ventilation are exempt from this regulation. (III)
- i.* Every facility shall provide a toilet with grab bars and lavatory for the public and staff. (III)

63.28(6) Heating. A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (III)

63.28(7) Water supply.

- a.* Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)
- b.* Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)
- c.* A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)
- d.* The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)
- e.* Hot and cold running water under pressure shall be available in the facility. (III)
- f.* Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department. (III)

63.28(8) Sewage system.

- a.* Sewage shall be collected and disposed of in a manner approved by the department. Disposal into a municipal system will be considered as meeting this requirement. (III)
- b.* Private sewage systems shall conform to the rules and regulations of the department of environmental quality, state health department, and the natural resources council. (III)
- c.* Every facility shall have an interior plumbing system complete with flushing device. (III)

63.28(9) Attendant's station. In facilities over 15 beds, an attendant's station with a minimum of 40 square feet shall be provided which is centrally located in the resident area and shall have a well-lighted desk with the necessary equipment for the keeping of required records and supplies. (III)

481—63.29(135C) Family and employee accommodations.

63.29(1) Children under 14 years of age shall not be allowed into the service areas in facilities of more than 15 beds. (III)

63.29(2) The residents' bedrooms shall not be occupied by employees, family members of employees, or family members of the licensee. (III)

63.29(3) In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

63.29(4) In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

63.29(5) In facilities of more than 15 beds, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

481—63.30(135C) Animals. No animals shall be allowed within the facility except with written approval of the department and under controlled conditions. (III)

481—63.31(135C) Environment and grounds.

63.31(1) A residential care facility for the mentally retarded shall be constructed in a neighborhood free from excessive noise, dirt, polluted or odorous air, or similar disturbances. (III)

63.31(2) There shall be an area available for outdoor activities calculated at 25 square feet per licensed bed. (III) Open-air porches may be included in meeting such requirement.

481—63.32(135C) Supplies.

63.32(1) Linen supplies.

a. There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

b. A complete change of bed linens shall be available in the linen storage area for each bed. (III)

c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)

d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

e. Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

63.32(2) First-aid kit. A first-aid emergency kit shall be available on each floor in every facility. (II, III)

63.32(3) General supplies.

a. All equipment shall be properly cleaned and sanitized before use by another resident. (III)

b. Clean and sanitary storage shall be provided for equipment and supplies. (III)

481—63.33(135C) Residents' rights in general.

63.33(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 63.33(2) to 63.33(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

63.33(2) Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

a. Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)

b. As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

63.33(3) Policies and procedures regarding the use of chemical and physical restraints shall define the use of restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

63.33(4) Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

63.33(5) Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II)

63.33(6) Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. The information must be provided upon admission or in the case of residents already in the facility upon the facility's adoption or amendment of resident right policies.

a. The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

b. Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English-speaking or deaf, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

c. A statement shall be signed by the resident, or responsible party, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party, if applicable. In the case of a mentally retarded resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

d. In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

e. All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English-speaking, deaf, or blind residents of such changes. (II)

63.33(7) Each resident or responsible party shall be fully informed in a contract as required in rule 481—63.14(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges not covered by the facility's basic per diem rate. (II)

63.33(8) Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the department of health and human services protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or mentally retarded individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

a. The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either, shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

b. The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

c. If the physician determines or in the case of a confused or mentally retarded resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

d. Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended December 1, 1981 (45 CFR 46). A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

481—63.34(135C) Involuntary discharge or transfer.

63.34(1) A facility shall not involuntarily discharge or transfer a resident from a facility except: for medical reasons; for the resident's welfare or that of other residents; for nonpayment for the resident's stay (as contained in the contract for the resident's stay), and by reason of action pursuant to Iowa Code chapter 229. (I, II)

a. "Medical reasons" for transfer or discharge are based on the resident's needs and are determined and documented in the resident's record by the attending physician. Transfer or discharge may be required to provide a different level of care. (II)

b. "Welfare" of a resident or that of other residents refers to their social, emotional, or physical well-being. A resident might be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with their needs and rights). Evidence that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall be in writing and shall include specific information to support this determination. (II)

c. Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. The 30-day requirement shall not apply in any of the following instances:

(1) If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) If the transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, physician, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

d. The notice required by paragraph "c" shall contain all of the following information:

(1) The stated reason for the proposed transfer or discharge. (II)

(2) The effective date of the proposed transfer or discharge. (II)

(3) A statement in not less than 12-point type (elite), which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department of inspections and appeals designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083." (II)

e. A request for a hearing made under 63.34(1) “d”(3) shall stay a transfer or discharge pending a hearing or appeal decision. (II)

f. The type of hearing shall be determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the licensee, resident, responsible party, and Iowa department on aging long-term care ombudsman of record not later than five full business days after receipt of the request. This notice shall also inform the licensee, resident or responsible party, that they have a right to appear at the hearing in person or be represented by their attorneys or other individual. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department on aging long-term care ombudsman shall have the right to appear at the hearing.

g. The hearing shall be heard by a department of inspections and appeals designee pursuant to Iowa Code chapter 17A. (The hearing shall be public unless the resident or the resident’s representative requests in writing that it be closed.) The licensee or designee shall have the opportunity to present to the representative of the department any oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and responsible party shall also have an opportunity to present to the representative of the department any oral testimony or written material to show just cause why a transfer or discharge should not be made. In a determination as to whether a transfer or discharge is authorized, the burden of proof rests on the party requesting the transfer or discharge.

h. Based upon all testimony and materials submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by certified mail to the licensee, resident, responsible party, and department on aging long-term care ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision.

i. A copy of the notice required by paragraph “c” shall be personally delivered to the resident and a copy placed in the resident’s record. A copy shall also be transmitted to the department, the resident’s responsible party, physician, the person or agency responsible for the resident’s placement, maintenance, and care in the facility, and the department on aging long-term care ombudsman.

j. If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

k. The involuntary transfer or discharge shall be discussed with the resident, the resident’s responsible party, and the person or agency responsible for the resident’s placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator’s designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident’s record. (II)

l. The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident’s record. (II)

(1) Counseling shall be provided by a qualified individual who meets one of the following criteria:

1. Has a bachelor’s or master’s degree in social work from an accredited college. (II)

2. Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with public or private agency. (II)

3. Has been employed in a social work capacity for a minimum of four years in a public or private agency. (II)

4. Is a licensed psychologist or psychiatrist. (II)

5. Is any other person of the resident's choice. (II)

(2) The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be discharged or transferred. (II)

(3) The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

m. In the case of an emergency transfer or discharge as outlined in 63.34(1)“c”(1), the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident's file and it must contain all the information required by 63.34(1)“d”(1) and (2). In addition, the notice must contain a statement in not less than 12-point type (elite), which reads: “You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa state department of inspections and appeals within 7 days after receiving this notice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.” A hearing requested pursuant to this subrule shall be held in accordance with paragraphs “f,” “g,” and “h.” (II)

n. Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility's license by the department of inspections and appeals. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

63.34(2) Intrafacility transfer:

a. Residents shall not be relocated from room to room within a licensed health care facility arbitrarily. (I, II) Involuntary relocation may occur only in the following situations and such situation shall be documented in the resident's record.

(1) Incompatibility with or disturbing to other roommates, as documented in the resident's record.

(2) For the welfare of the resident or other residents of the facility.

(3) For medical, nursing or psychosocial reasons, as documented in the resident's record, as judged by the attending physician, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.

(4) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex.

(5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

b. Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident, or responsible party include:

(1) Change from private pay status to Title XIX, except as outlined in 63.34(2)“a”(5). (II)

(2) As punishment or behavior modification (except as specified in 63.34(2)“a”(1). (II)

(3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph “a,” the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. Notification shall be documented in the resident's record and signed by the resident or responsible party. (II)

d. If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family or responsible party shall be notified immediately or as soon as possible of the condition requiring emergency relocation and the notification shall be documented. (II)

481—63.35(135C) Resident rights. Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise the resident's rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

63.35(1) The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

63.35(2) The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

- a.* Designation of an employee responsible for handling grievances and recommendations. (II)
- b.* A method of investigating and assessing the validity of a grievance or recommendation. (II)
- c.* Methods of resolving grievances. (II)
- d.* Methods of recording grievances and actions taken. (II)

63.35(3) The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, care review committee members, the text of Iowa Code section 135C.46, etc., to provide to residents a further course of redress. (II)

481—63.36(135C) Financial affairs—management. Each resident, who has not been assigned a guardian or conservator by the court, may manage personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

63.36(1) The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

63.36(2) An employee shall be designated in writing to be responsible for resident accounts. (II)

63.36(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or mentally retarded resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

63.36(4) If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge having seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

63.36(5) A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

63.36(6) A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

481—63.37(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental and physical abuse. Each resident shall be free from chemical and physical restraints, except in an emergency for the shortest amount of time necessary to protect the resident from injury to the resident or to others, pending the immediate transfer to an appropriate facility. The decision to use restraints on an emergency basis shall be made by the designated charge person who shall promptly report the action taken to the physician and the reasons for using restraints shall be

documented in the resident's record. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

63.37(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

63.37(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

63.37(3) Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff or as a substitute for program. (II)

63.37(4) Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain that separation until the abuse investigation is completed. (I, II)

63.37(5) Suspected abuse reports. The department shall investigate all complaints of dependent adult abuse which are alleged to have happened in a health care facility. The department shall inform the department of human services of the results of all evaluations and dispositions of dependent adult abuse investigations.

63.37(6) Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

This rule is intended to implement Iowa Code subsections 235B.3(1) and 235B.3(11).

481—63.38(135C) Resident records. Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

63.38(1) The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

63.38(2) Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

63.38(3) The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

481—63.39(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of the resident's dignity and individuality, including privacy in treatment and in care for the resident's personal needs. (II)

63.39(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

63.39(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment,

sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

63.39(3) Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

63.39(4) Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

63.39(5) Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply under emergency conditions. (II)

481—63.40(135C) Resident work. No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. (II)

63.40(1) Residents may not be used to provide a source of labor for the facility against their will. Physician's approval is required for all work programs. (I, II)

63.40(2) If the plan of care requires activities for therapeutic or training reasons, the plan for these activities shall be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time-limited and reviewed at least quarterly. (II)

63.40(3) Residents who perform work for the facility must receive remuneration unless such work is part of their approved training program. Persons on the resident census performing work shall not be used to replace paid employees in fulfilling staff requirements. (II)

481—63.41(135C) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

63.41(1) Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

63.41(2) Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- a. The resident refuses to see the visitor. (II)
- b. The resident's physician documents specific reasons why such a visit would be harmful to the resident's health. (II)
- c. The visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

63.41(3) Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician; at least quarterly by the facility's staff; or at the resident's request. (II)

63.41(4) Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

63.41(5) Telephones consistent with ANSI standards (405.1134(c)) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

63.41(6) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

63.41(7) Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified mental retardation professional or facility administrator for refusing permission. (II)

63.41(8) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

481—63.42(135C) Resident activities. Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the attending physician or qualified mental retardation professional as appropriate in the resident's record. (II)

63.42(1) Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

63.42(2) All residents shall have the freedom to refuse to participate in these activities. (II)

481—63.43(135C) Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

63.43(1) Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

63.43(2) Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

63.43(3) Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart. The facility shall be responsible for secure storage of such items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

63.43(4) A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

63.43(5) A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

481—63.44(135C) Family visits. Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room, if possible. (II)

63.44(1) The facility shall provide for needed privacy in visits between spouses. (II)

63.44(2) Spouses who are residents in the same facility shall be permitted to share a room, if available, unless one of their attending physicians documents in the medical record those specific reasons why an arrangement would have an adverse effect on the health of the resident. (II)

63.44(3) Family members shall be permitted to share a room, if available, if requested by both parties, unless one of their attending physicians documents in the medical record those specific reasons why such an arrangement would have an adverse effect on the health of the resident. (II)

481—63.45(135C) Choice of physician. Each resident shall be permitted free choice of a physician and a pharmacy, if accessible. The facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility. (II)

481—63.46(135C) Incompetent resident.

63.46(1) Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

63.46(2) The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

481—63.47(135C) Specialized license for three- to five-bed facilities. The specialized license is for residential care facilities which serve persons with mental retardation, chronic mental illness and other developmental disabilities having five or fewer residents as specified in Iowa Code section 225C.26. The facility is exempt from Iowa Code section 135.63. For this specialized license, all rules of 481—Chapter 63 apply except those which are deleted or amended, as indicated in subsequent rules.

63.47(1) The provider may apply for a specialized license from the department of inspections and appeals. Before the license is granted, the provider shall meet all of the following requirements:

a. Compliance with program requirements pursuant to Iowa Code chapter 135C and administrative rules relating to residential care facilities adopted by the state board of health, or standards adopted by the Accreditation Council for Services for Persons with Mental Retardation and Other Developmental Disabilities (1984). The program of care shall emphasize an age-appropriate and least restrictive program.

b. The facility shall be located in areas zoned for single- or multiple-family housing, or be located in an unincorporated area, and shall be constructed in compliance with applicable local housing codes and rules adopted for this classification of license by the state fire marshal. (II, III)

c. The facility shall be appropriately accessible to residents who have disabilities. (II, III)

d. Written plans shall demonstrate that the facility meets the needs of the residents pursuant to individual program plans meeting age-appropriate and least restrictive program requirements. (II)

e. Written plans shall demonstrate the residents have reasonable access to employment for job-related training, education, generic community resources, or integrated opportunities to promote community interaction. (II)

f. Unless documented as appropriate within the residents' individual program plans, populations with primary diagnosis of chronic mental illness or mental retardation/developmental disability may not be residents of the same specialized license facility. (II, III)

63.47(2) The housing for persons with mental retardation, chronic mental illness, and other developmental disabilities, developed pursuant to this rule shall be eligible for funding utilized by licensed residential care facilities for the mentally retarded.

63.47(3) Rescinded IAB 6/27/90, effective 8/1/90.

63.47(4) Rescinded IAB 6/27/90, effective 8/1/90.

63.47(5) The director of the department of inspections and appeals shall appoint a specialized license committee not to exceed nine members. This committee shall monitor the program rules and procedures adopted for this classification of license.

63.47(6) All conditions and criteria in 481—Chapter 63 apply to the specialized license with the exception of the following deletions: 481—63.7(135C), 63.8(2)“b,” 63.8(7)“b,” 63.13(1)“l,” 63.18(1)“b” (9), 63.19(1)“a,” “b,” “c,” 63.19(2)“c”(1), “e,” “g,” 63.19(4)“a,” “b,” “c,” “g,” “h,” “i,” “l,” “n,” “p,” “q,” “r,” “t,” 63.19(5)“b,” “c,” “d,” 63.21(1), (2), (3) “a” to “e,” (4)“a,” “b,” “c”(1) to (3), “d,” “e,” 63.21(5)“c,” 63.23(3)“c,” 63.23(4)“c,” “d,” 63.24(1), (7), (10), 63.25(10)“b,” 63.26(1) to (4), (6)“b,” 63.27(3) to (5), 63.28(1)“a,” “b,” “f,” “g,” “k,” “l,” “m,” “o,” 63.28(2)“c,” 63.28(3)“a,” “d,” “e,” “f”(3), “g”(2), 63.28(5)“b,” “i,” 63.28(9), 63.29(1), (4), (5), 63.33(6)“d.”

63.47(7) The following rules in Chapter 63 are amended for this specialized license as follows:

1. 63.3(1)“a” and 63.3(2)—Delete all references to 481—Chapter 60.

2. 63.8(1)“a”—Add “or qualified mental health professional (III)” after “qualified mental retardation professional”. (III)

3. 63.8(2)—Add “For purposes of the specialized license, the administrator may act as an administrator for not more than three residential care facilities for the mentally retarded, chronic mentally ill, and developmentally disabled.” (II)

4. 63.9(1)—Add “For purposes of the specialized license there shall be written personnel policies in all facilities to include hours of work and attendance at the education program.” (III)

5. 63.11(1)“a”—Delete the words “a managerial role of” in line 2.

6. 63.11(2)“b”—Delete the second sentence and “with 15 or less beds” in the third sentence.

7. 63.14(5)“b”—Add “or guardian” after “resident” in the first line.

8. 63.17(1)—Add a new paragraph: “v. Current Individual Program Plans (IPP)”.
9. 63.17(5) “a”—Add “For the specialized license, a job description shall be in the individual’s personnel file.” (III)
10. 63.19(2) “b”—Delete from the end “Recommended daily dietary allowances are:” Also delete subparagraphs (1) to (5).
11. 63.19(2) “f”—Delete the second sentence.
12. 63.19(3) “e”—Delete “for a minimum of a one-week period” in the first line.
13. 63.19(4) “m”—Delete “smooth, washable,” in the second line.
14. 63.19(4) “o”—Delete the second sentence.
15. 63.19(4) “s”—Add “and rinse” after “wash” in the first line and then delete the rest of the sentence after “(60°C)”.
16. 63.19(4) “w”—Change “or” to “and” in the first line and delete “,washing, sanitizing, and air-drying”.
17. 63.19(5) “b”—Delete the second sentence.
18. 63.19(5) “f”—Add “during food preparation” after “kitchen”.
19. 63.24(9)—Change “nonslip” to “slip-resistant” in the first sentence.
20. 63.25(1)—Delete the second sentence.
21. 63.28(1) “j”—Change “on both sides” in the first line to “on at least one side”.
22. 63.28(4) “n”—Change to read “Bedrooms shall have a minimum of 60 square feet for double, 80 square feet for single, and 100 square feet physical (wheelchair).” (III)
23. 63.28(4) “o”—Change “four” to “two”.
24. 63.28(5) “c”—Amend to read: “Minimum numbers of toilets and bath facilities shall be one for each five residents.” (III)
25. 63.28(5) “d”—Amend to read: “There shall be a minimum of one bathroom with tub or shower, toilet stool, and lavatory on each floor in the multistory buildings.” (III)
26. 63.28(5) “e”—Amend to read: “Grab bars shall be provided as needed.” (III)
27. 63.33(8)—Change any reference of “responsible party” to “legal guardian”.
28. 63.33(8) “c”—Delete “in the case of a confused or mentally retarded resident”. Change any reference of “responsible party” to “legal guardian”.
29. 63.33(8) “d”—Change any reference of “responsible party” to “legal guardian”.
30. 63.46(1)—Change any reference of “responsible party” to “legal guardian” and delete the rest of the paragraph after “state law”.

63.47(8) “Qualified mental health professional” is a person who:

- a. Holds a master’s degree from an accredited educational institution with coursework relevant to the position for which the person is hired;
- b. Has at least two years’ relevant experience supervised by a qualified mental health professional in assessing mental health problems and needs of persons in providing appropriate mental health services for those persons;
- c. Holds a current Iowa license when required by Iowa licensure law.

63.47(9) “Mental retardation” as used in this chapter shall also include the chronically mentally ill and the developmentally disabled for purposes of this specialized license.

a. For the specialized license, “persons with mental retardation” means persons with significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, manifested during the developmental period.

(1) “General intellectual functioning” is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning;

(2) “Significantly subaverage functioning” is defined as approximately 70 IQ or below;

(3) “Adaptive behavior” is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group;

(4) “Developmental period” is defined as the period of time between conception and the eighteenth birthday.

b. For the specialized license, “persons with developmental disabilities” means persons with a severe, chronic disability which:

- (1) Is attributable to mental or physical impairment, or a combination of physical and mental impairments;
- (2) Is manifested before the person attains the age of 22;
- (3) Is likely to continue indefinitely;
- (4) Results in substantial functional limitations in three or more of the following areas of life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency; and
- (5) Reflects the person’s need for a combination and sequence of services which are of lifelong or extended duration.

c. For the specialized license, “persons with chronic mental illness” means adults aged 18 or older, with persistent mental or emotional disorders that seriously impair their functioning relative to such primary aspects of daily living as personal relations, living arrangement or employment. Persons with chronic mental illness typically meet at least one of the following criteria:

- (1) Have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization or in-patient hospitalization);
- (2) Have experienced a single episode of continuous, structured supportive residential care other than hospitalization.

In addition, such persons typically meet at least two of the following criteria, on a continuing or intermittent basis for at least two years:

1. Are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history;
2. Require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help;
3. Show severe inability to establish or maintain a personal social support system;
4. Require help in basic living skills;
5. Exhibit inappropriate social behavior which results in demand for intervention by the mental health or judicial system.

In atypical instances chronically mentally ill persons may vary from the above criteria.

63.47(10) For the specialized license, there shall be implemented an individual program plan (IPP) of goals and objectives for each resident developed using evaluations, assessments and progress reports. (II)

63.47(11) For the specialized license, “age-appropriate” shall mean activities, settings, personal appearance and possessions commensurate with the person’s chronological age.

63.47(12) For the specialized license, “least restrictive” shall mean the availability to the person of programs, services and settings that give the greatest opportunity for human development and to associate with and become part of the general society.

63.47(13) “Individual program plan” shall be a written plan for the provision of services to the person and, when appropriate, to the person’s family, that is developed and implemented, using an interdisciplinary process, which identifies the person’s and, when appropriate, the person’s family’s functional status, strengths, and needs, and service activities designed to enable a person to maintain or move toward independent functioning. The plan is developed in accordance with the developmental model, which is a service approach that recognizes and assumes the potential for positive change, growth, and sequential development in all people. (II)

a. An individual program plan shall be developed and implemented for each individual accepted for service, regardless of the individual’s chronological age or developmental level. (I, II)

b. The interdisciplinary team shall develop the plan. (II) For the purpose of the specialized license, the team shall include:

(1) The person, the person's legal guardian, and the person's family unless the family's participation is contrary to the wishes of the adult person who has not been legally determined to be incompetent; (II, III)

(2) The service coordinator or case manager; (II, III)

(3) All current service providers; and (II, III)

(4) Other persons whose appropriateness may be identified through the diagnosis and evaluation or current reevaluation. (III)

c. The person or the person's legal guardian has the ultimate authority to accept or reject the plan unless otherwise determined by court. (III)

d. The resident and the facility retain the rights of appeal and due process from the interdisciplinary team decisions. (II, III)

63.47(14) Goals and objectives shall be stated separately and a time frame shall be specified for their achievement. (II, III)

a. Each individual enrolled shall have an individual program plan. (II)

b. The initial individual program plan shall be developed within 30 calendar days after the individual is enrolled in this service. (II)

c. The individual program shall be developed by an appropriately constituted interdisciplinary team. (II)

d. The individual program plan shall state specific objectives to reach identified goals and shall identify the individuals responsible for implementation. (II, III)

e. Goals and objectives shall be stated separately. (II, III)

f. Goals and objectives shall be assigned projected evaluation completion dates and shall be reviewed at least annually. (II, III)

g. Goals and objectives shall be expressed in behavioral terms that provide measurable indices of progress. (II)

h. Goals and objectives shall be sequenced with a developmental progression appropriate to the individual. (II, III)

i. Goals and objectives of the individual program plans shall be assigned priorities by the interdisciplinary team and implemented with documentation of needed resources. (II, III)

j. The individual program plan shall be written in terms that are understandable to all concerned. (II, III)

63.47(15) Where implementation is a shared responsibility, the individual program plan shall identify the agencies or persons responsible for delivering the services required. (III)

63.47(16) A review of the individual program plan shall be made at least quarterly by a member or members of the individual's interdisciplinary team, as determined by the team, in order to ensure the continuing implemented appropriateness of the plan and any necessary action to be initiated. (II)

a. Problems or changes that call for review of the individual program plan by the team shall be indicated. (II)

b. The team shall be convened at least annually to review the individual program plan where problems or changes that call for review by the team are indicated. (II, III)

c. The team review shall assess the individual's response to activities designed to achieve the objective stated in the individual program plan. (II, III)

d. The team review shall modify activities or objectives as necessary. (II, III)

e. The team review shall determine the services that are needed. (II, III)

f. The team review shall include consideration of the advisability of continued enrollment or alternative placements. (II, III)

481—63.48(135C) County care facilities. In addition to Chapter 63 licensing rules, county care facilities licensed as residential care facilities for the mentally retarded must also comply with department of human services rules, Iowa Administrative Code 441—Chapter 37. Violation of any standard established by the department of human services is a Class II violation pursuant to Iowa Administrative Code 481—56.2(135C).

481—63.49(135C) Another business or activity in a facility. A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs “a” through “j” of this rule. (I, II, III)

63.49(1) The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a. Health and safety risks for residents;
- b. Compatibility of the proposed business or activity with the facility program;
- c. Noise created by the proposed business or activity;
- d. Odors created by the proposed business or activity;
- e. Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- f. Use of the facility’s corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- g. Proposed staffing for the business or activity;
- h. Sharing of services and staff between the proposed business or activity and the facility;
- i. Facility layout and design; and
- j. Parking area utilized by the business or activity.

63.49(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

63.49(3) A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 60. (I, II, III)

481—63.50(135C) Respite care services. Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A facility which chooses to provide respite care services must meet the following requirements related to respite care services and must be licensed as a health care facility.

63.50(1) A facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

63.50(2) Rules regarding involuntary discharge or transfer rights do not apply to residents who are being cared for under a respite care contract.

63.50(3) The facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements for contracts between a health care facility and resident, except the requirements concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons.

63.50(4) Respite care services shall not be provided by a facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.1, 135C.2(5), 135C.2(6), 135C.6(1), 135C.14(3), 135C.14(5), 135C.14(8), 135C.25, 135C.25(3), 135C.36, 227.4, 235B.1(6), and 235B.1(11) and 1988 Iowa Acts, chapter 1239.

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◊ Two or more ARCs

¹ Effective date of 63.15(2)“a” and “b” delayed 70 days by the Administrative Rules Review Committee, IAB 2/26/86.
 Effective date of 63.15(2)“a” and “b” delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAC 6/4/86.

² See IAB, Inspections and Appeals Department.

³ Two ARCs

⁴ Rule 481—63.49(135C), effective 7/1/92.

CHAPTER 65
INTERMEDIATE CARE FACILITIES
FOR PERSONS WITH MENTAL ILLNESS (ICF/PMI)

481—65.1(135C) Definitions. For the purposes of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered incorporated verbatim in the rules. The use of the words “shall” and “must” indicate these standards are mandatory.

“*Abuse*” means any of the following as a result of the willful or negligent acts or omissions of a caretaker:

1. Physical abuse;
2. Physical injury to or unreasonable confinement or cruel punishment of a resident;
3. Sexual abuse;
4. Mental abuse;
5. Verbal abuse;
6. Exploitation of a resident; or
7. The deprivation of the minimum food, shelter, clothing, supervision, physical and mental health care, and other care necessary to maintain a resident’s life or health as a result of the acts or omissions of the caretaker.

“*Academic services*” means those activities provided to assist a person to acquire general information and skills which establish the basis for subsequent acquisition and application of knowledge.

“*Activity coordinator*” means a person who has completed the state-approved activity coordinator’s course.

“*Age appropriate*” means those activities, settings, and personal appearance and possessions commensurate with the person’s chronological age.

“*Chronic mental illness*” (see the definition of “Mental illness”).

“*Commission*” means the mental health and mental retardation commission.

“*Community living training services*” are those activities provided to assist a person to acquire or sustain the knowledge and skills essential to independent functioning to the person’s maximum potential in the physical and social environment. These services may focus on the following areas:

1. Independent living skills which include those skills necessary to sustain oneself in the physical environment and are essential to the management of one’s personal property and business. This includes self-advocacy skills.
2. Socialization skills which include self-awareness and self-control, social responsiveness, group participation, social amenities and interpersonal skills.
3. Communication skills which include expressive and receptive skills in verbal and nonverbal language, including reading and writing.
4. Leisure time and recreational skills which include the skills necessary for a person to use leisure time in a manner which is satisfying and constructive to the person.
5. Parenting skills which include those skills necessary to meet the needs of the person’s child. This service is designed to assist the person with mental illness to acquire or sustain the skills necessary for parenting.

“*Department*” means the Iowa department of inspections and appeals.

“*Diagnosis*” means the investigation and analysis of the cause or nature of a person’s condition, situation or problem.

“*Direct care staff*” means those staff persons who provide a homelike environment for the residents and assist or supervise the resident in meeting the goals in the resident’s program plan.

“*Evaluation services*” means those activities designed to identify a person’s current functioning level and those factors which are barriers to maintaining the current level or achieving a higher level of functioning.

“Exploitation” means the act or process of taking unfair advantage of a resident, or the resident’s physical or financial resources for one’s own personal or pecuniary profit by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

“Goals” means general statements of attainable expected accomplishments to be achieved in meeting identified needs.

“Incident” means all accidental, purposeful, or other occurrences within the facility or on the premises affecting residents, visitors, or employees whether there is apparent injury or where hidden injury may have occurred.

“Individual program plan (IPP)” means a written plan for the provision of services to the resident that is developed and implemented using an interdisciplinary process that is based on the resident’s functional status, strengths, and needs and that identifies service activities designed to enable a person to maintain or move toward independent functioning. The plan identifies a continuum of development and outlines progressive steps and anticipated outcomes of services.

“Informed consent” means an agreement by a person, or by the person’s legally authorized representative, based upon an understanding of:

1. A full explanation of the procedures to be followed including an identification of those that are and are not experimental;

2. A description of the attendant discomforts, risks, and benefits to be expected; and

3. A disclosure of appropriate alternative procedures that would be advantageous for the person.

“Interdisciplinary process” means an approach to assessment, individual program planning, and service implementation in which planning participants function as a team. Each participant utilizing the skills, competencies, insights and perspectives provided by the participant’s training and experience focuses on identifying the service needs of the resident and the resident’s family. The purpose of the process is for participants to review and discuss, face-to-face, all information and recommendations and to reach decisions as a team. Participants share all information and recommendations, and develop as a team, a single, integrated individual program plan to meet the resident’s needs and, when appropriate, the resident’s family’s needs.

“Interdisciplinary team” means the group of persons who develop a single, integrated individual program plan to meet a resident’s needs for services. The interdisciplinary team consists of, at a minimum, the resident, the resident’s legal guardian, if applicable, the resident’s advocate, if desired by the resident, a referral agency representative, other appropriate staff members, the resident’s attending psychiatrist and QMHP, other providers of services, and other persons relevant to the resident’s needs.

“Least restrictive environment” means the environment in which the interventions in the lives of people with mental illness can be carried out with a minimum of limitation, intrusion, disruption, and departure from commonly accepted patterns of living.

It is the environment which allows residents to participate, to the maximum extent possible, in everyday life and to have control over the decisions that affect them. It is an environment that provides needed supports which do not interfere with personal liberty and do not unduly interfere with a person’s access to the normal events of life.

“Legal services” means those activities designed to assist the person in exercising constitutional and legislatively enacted rights.

“Level of functioning” means a person’s current physiological and psychological status and current academic, community living, self-care and vocational skills.

“Mechanical restraint” means a device applied to a person’s limbs, head or body which restricts a person’s movement and includes, but is not limited to, leather straps, leather cuffs, camisoles or handcuffs.

“Mental abuse” means, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

“Mental health counselor” means a person who is certified or eligible for certification as a mental health counselor by the National Academy of Certified Clinical Mental Health Counselors.

“Mental health, mental retardation commission” means the commission described in Iowa Code section 225C.5.

“Mental illness” means a substantial disorder of thought or mood which significantly impairs judgment, behavior, or the capacity to recognize reality or the ability to cope with the ordinary demands of life. Mental illnesses include the organic and functional psychoses, neuroses, personality disorders, alcoholism and drug dependence, behavioral disorders and other disorders as defined by the current edition of “American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.” Mental illness is chronic when it is of long duration or marked by frequent recurrences.

“Normalization” means helping persons, in accordance with their needs and preferences, to achieve a lifestyle that is consistent with the norms and patterns of general society in ways which incorporate the age-appropriate and least restrictive principles.

“Objectives” means specific, time-limited, and measurable statements showing outcomes or accomplishments necessary to progress toward the goal.

“Physical abuse” means, but is not limited to, corporal punishment and the use of restraints as punishment.

“Physical injury” means damage to any bodily tissue to the extent the tissue must undergo a healing process in order to be restored to a sound and healthy condition. It may also mean damage to the extent the bodily tissue cannot be restored to a sound and healthy condition, or results in the death of the resident whose bodily tissue sustained the damage.

“Physical or physiological treatment” means those activities designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the physical or physiological functioning of the human body.

“Physical restraint” means a technique involving the use of one or more of a staff person’s arms, legs, hands or other body areas to restrict or control the movements of a resident. This does not include the use of mechanical restraint.

“Physician” means a person who is currently licensed in Iowa to practice medicine and surgery, osteopathic medicine and surgery, or osteopathy.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for any of the following:

1. Special target populations;
2. The population of a specified geographic area(s);
3. A specified purpose; and
4. A person.

“Psychiatric nurse” means a person who meets the requirements of certified psychiatric-mental health nurse practitioner pursuant to 655—Chapter 7, Iowa Administrative Code, or is eligible for certification.

“Psychiatrist” means a doctor of medicine or osteopathic medicine and surgery who is certified by the American Board of Psychiatry and Neurology or who is eligible for certification.

“Psychologist” means a person who is licensed to practice psychology in the state of Iowa, or is certified by the Iowa department of education as a school psychologist, or is eligible for certification.

“Psychotherapeutic treatment” means those activities designed to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person’s functioning in response to the physical, emotional and social environment.

“Qualified mental health professional (QMHP)” means a person who:

1. Holds at least a master’s degree in a mental health field, including but not limited to: psychology, counseling and guidance, nursing and social work; or is a doctor of medicine (M.D.) or a doctor of osteopathic medicine and surgery (D.O.); and
2. Holds a current Iowa license when required by the Iowa licensure law; and
3. Has at least two years of postdegree experience, supervised by a mental health professional, in assessing mental problems and needs of individuals and in providing appropriate mental health services for those individuals. See rule 481—65.4(135C) for variance procedures.

“Resident” means a person who has been admitted to the facility to receive care and services.

“Seclusion” means the isolation of the resident in a locked room which cannot be opened by the resident.

“*Self-care training services*” means those activities provided to assist a person to acquire or sustain the knowledge, habits and skills essential to the daily needs of the person. The activities focus on personal hygiene, general health maintenance, mobility skills and other activities of daily living.

“*Service*” means a set of interrelated activities provided to a resident pursuant to the IPP.

“*Sexual abuse*” means, but is not limited to, the exposing of pubes to a resident, the exposure of a resident’s genitals, pubes, breasts or buttocks for sexual satisfaction, fondling or touching the inner thigh, groin, buttocks, anus or breast of a resident or the clothing covering these areas, sexually suggestive comments or remarks made to a resident, a genital to genital or rectal, or oral to genital or rectal contact, or the commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2.

“*Social worker*” means a person who is licensed to practice social work in the state of Iowa, or who is eligible for licensure.

“*Support services*” means those activities provided to or on behalf of a person in the areas of personal care and assistance and property maintenance in order to allow a person to live in the least restrictive environment.

“*Transportation services*” means those activities designed to assist a person to travel from one place to another to obtain services or carry out life’s activities.

“*Verbal abuse*” means, but is not limited to, the use of derogatory terms or names, undue voice volume and rude comments, orders or responses to residents.

“*Vocational training services*” means those activities designed to familiarize a person with production or employment requirements and to maintain or develop the person’s ability to function in a work setting. This service includes programming which allows or promotes the development of skills, attitudes and personal attributes appropriate to the work setting.

“*Work*” means any activity during which a resident provides goods or services for wages.

“*Written, in writing or recorded*” means that an account or entry is made in a permanent form.

481—65.2(135C) Application for license. In order to obtain an initial license for an ICF/PMI, the applicant must comply with the rules and standards contained in Iowa Code chapter 135C and the standards in 481—Chapter 61. Variances from Chapter 61 regulations are allowed under rule 481—61.2(135C). An application must be submitted to the department which states the type and category of license for which the facility is applying.

65.2(1) Each application shall include:

- a. A floor plan of each floor of the facility drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathroom, and designation of the use to which room will be put and window and door location;
- b. A photograph of the front and side elevation of the facility;
- c. The statutory fee for an intermediate care facility license;
- d. Evidence of a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules.

65.2(2) A résumé of care with a narrative which includes the following information shall be submitted:

- a. The purpose of the facility;
- b. A description of the target population and limitations on resident eligibility;
- c. An identification and description of the services the facility will provide. This shall include at least specific and measurable goals and objectives for each service available in the facility and a description of the resources needed to provide each service including staff, physical facilities and funds;
- d. A description of the human service system available in the area, including, but not limited to, social, public health, visiting nurse, vocational training, employment services, sheltered living arrangements, and services of private agencies;
- e. A description of working relationships with the human service agencies when applicable which shall include at least how the facility will coordinate with:

(1) The department of human services to facilitate continuity of care and coordination of services to residents; and

(2) Other agencies to identify unnecessary duplication of services and plan for development and coordination of needed services;

f. A list of members of the care review committee; and

g. A description of a program of training for the care review committee concerning their role in the ongoing care and treatment of residents.

65.2(3) In order to obtain a renewal or change of ownership license of the ICF/PMI the applicant must:

a. Submit to the department the completed application form 30 days prior to annual license renewal or change of ownership date of the ICF/PMI license;

b. Submit the statutory license fee for an ICF/PMI with the application for renewal or change of ownership;

c. Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules; and

d. Submit documentation of review of résumé of care pursuant to subrule 65.2(1), paragraph “a,” and a copy of any revisions to the plan.

This rule is intended to implement Iowa Code sections 135C.7 and 135C.9.

481—65.3(135C) Licenses for distinct parts. Separate licenses may be issued for distinct parts which are clearly identifiable parts of a health care facility, containing contiguous rooms in a separate wing or building or on a separate floor of the facility, which provide care and services of separate categories.

The following requirements shall be met for a separate licensing of a distinct part:

1. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part. (III)

2. The distinct part shall meet all the standards, rules and regulations pertaining to the category for which a license is being sought.

3. The distinct part must be operationally and financially feasible.

4. A separate personal care staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management. (III)

5. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry and dietary in common with each other.

This rule is intended to implement Iowa Code section 135C.6(2).

481—65.4(135C) Variances. Variances from these rules may be granted by the director of the department when:

1. The need for a variance has been established consistent with the résumé of care or the resident’s individual program plan.

2. There is no danger to the health, safety, welfare or rights of any resident.

3. The variance will apply only to a specific intermediate care facility for the mentally ill.

Variances shall be reviewed at least at the time of each licensure survey and any other time by the department to see if the need for the variance is still acceptable.

65.4(1) To request a variance, the licensee must:

a. Apply in writing on a form provided by the department;

b. Cite the rule or rules from which a variance is desired;

c. State why compliance with the rule or rules cannot be accomplished;

d. Explain how the variance is consistent with the résumé of care or the individual program plan; and

e. Demonstrate that the requested variance will not endanger the health, safety, welfare or rights of any resident.

65.4(2) Upon receipt of a request for variance, the director will:

a. Examine the rule from which the variance is requested;

- b.* Evaluate the requested variance against the requirement of the rule to determine whether the request is necessary to meet the needs of the residents;
- c.* Examine the effect of the requested variance on the health, safety or welfare of the residents;
- d.* Consult with the applicant to obtain additional written information if required; and
- e.* Obtain approval of the Iowa mental health and mental retardation commission, when the request is for a variance from the requirement for qualification of a mental health professional.

65.4(3) Based upon this information, approval of the variance will be either granted or denied within 120 days of receipt.

481—65.5(135C) General requirements.

65.5(1) A valid license shall be posted in each facility so the public can easily see it. (III)

65.5(2) Each license is valid only for the premises and person named on the license and is not transferable.

65.5(3) The posted license shall accurately reflect the current status of the facility. (III)

65.5(4) Each citation or a copy of each citation issued by the department for a Class I or Class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

65.5(5) Licenses expire one year after the date of issuance or as indicated on the license.

65.5(6) There shall be no more beds erected than are stipulated on the license. (II, III)

This rule is intended to implement Iowa Code section 135C.8.

481—65.6(135C) Notification required by the department. The department shall be notified within 48 hours, by letter, of any reduction or loss of personal care or dietary staff lasting more than seven days which places the staff ratio below that required for licensing. No additional residents shall be admitted until the minimum staff requirements are achieved. (II, III)

65.6(1) Other required notification and time periods are:

- a.* Within 30 days of any proposed change in the résumé of care for the ICF/PMI; (II, III)
- b.* Thirty days before addition, alteration, or new construction is begun in the ICF/PMI or on the premises; (III)
- c.* Thirty days before the ICF/PMI closes; (III)
- d.* Within two weeks of any change of administrator; (II, III) and
- e.* Within 30 days when any change in the category of license is sought. (III)

65.6(2) Prior to the purchase, transfer, assignment, or lease of an ICF/PMI the licensee shall:

- a.* Inform the department in writing of the pending sale, transfer, assignment, or lease of the facility; (III)
- b.* Inform the department in writing of the name and address of the prospective purchaser, transferee, assignee or lessee at least 30 days before the sale, transfer, assignment or lease is completed; (III) and
- c.* Submit a written authorization to the department permitting the department to release information of whatever kind from the department's files concerning the licensee's ICF/PMI to the named prospective purchaser, transferee, assignee or lessee. (III)

65.6(3) After the authorization has been submitted to the department, the department shall upon request send or give copies of all recent licensure surveys and any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee or lessee. Costs for copies requested shall be paid by the prospective purchaser, transferee, assignee or lessee. No information personally identifying any resident shall be provided to the prospective purchaser, transferee, assignee or lessee. (II, III)

This rule is intended to implement Iowa Code sections 135C.6(3) and 135C.16(2).

481—65.7(135C) Administrator. Each ICF/PMI shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. (II, III)

65.7(1) The administrator shall be at least 21 years of age and shall meet at least one of the following conditions:

a. Be licensed in Iowa as a nursing home administrator, or certified as a residential care administrator. No residential care facility administrator certified under a waiver from the department shall administrate an intermediate care facility for persons with mental illness. The administrator must have at least two years' experience in direct care or supervision of people with mental illness and at least one year of experience in an administrative capacity; (II, III) or

b. Be a qualified mental health professional (QMHP) with at least one year of experience in an administrative capacity. (II, III)

If an ICF/PMI is a distinct part of a licensed health care facility, the administrator of the facility as a whole may serve as the administrator of the ICF/PMI without meeting the requirements of subrule 65.7(1), paragraph "a" or "b." When this occurs, the person in charge of the ICF/PMI distinct part shall meet the requirements of subrule 65.7(1), paragraph "a" or "b." (II, III)

65.7(2) The administrator of more than one facility shall be responsible for no more than 150 beds in total. (II, III)

a. The distance between the two farthest facilities shall be no greater than 50 miles. (II, III)

b. An administrator of more than one facility must designate an administrative staff person in each facility who shall be responsible for directing programs in the facility during the administrator's absence. (II, III)

65.7(3) The administrative staff person shall be designated in writing and immediately available to the facility on a 24-hour basis when the administrator is absent and residents are in the facility. (II, III)

The person(s) designated shall:

a. Have at least two years' experience or training in a supervisory or direct care position in a mental health setting; (II, III)

b. Be knowledgeable of the operation of the facility; (II, III)

c. Have access to records concerned with the operation of the facility; (II, III)

d. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (II, III)

e. Be at least 21 years of age; (III)

f. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety and welfare of the residents; (II, III) and

g. Have training to carry out assignments and take care of emergencies and sudden illnesses of residents. (II, III)

65.7(4) If an administrator serves more than one facility, a written plan shall be developed, implemented and available for review by the department designating regular and specific times the administrator will be available to meet with the staff and residents to provide direction and supervision of resident care and services. (II, III)

65.7(5) When a facility has been unable to replace the administrator, through no fault of its own, a provisional administrator meeting the qualifications of the administrative staff person may be appointed on a temporary basis by the licensee to assume the administrative responsibilities for the facility. This person shall not serve more than three months without approval from the department. The department must be notified before the appointment of the provisional administrator. (III)

65.7(6) A facility applying for initial licensing shall not have a provisional administrator. (III)

This rule is intended to implement Iowa Code section 135C.14(2).

481—65.8(135C) Administration.

65.8(1) The licensee shall:

a. Be responsible for the overall operation of the ICF/PMI; (III)

b. Be responsible for compliance with all applicable laws and with the rules of the department; (II, III)

c. Establish written policies, which shall be available for review by the department or other agencies designated by Iowa Code section 135C.16(3), for the operation of the ICF/PMI including, but not limited to: (III)

- (1) Personnel; (III)
- (2) Admission; (III)
- (3) Evaluation services; (II, III)
- (4) Programming and individual program plan; (II, III)
- (5) Crisis intervention; (II, III)
- (6) Discharge or transfer; (III)
- (7) Medication management; (II)
- (8) Resident property; (II, III)
- (9) Financial affairs; (II, III)
- (10) Records; (III)
- (11) Health and safety; (II, III)
- (12) Nutrition; (III)
- (13) Physical facilities and maintenance; (III)
- (14) Care review committee; (III)
- (15) Resident rights; (II, III) and

d. Furnish statistical information concerning the operation of the facility to the department within 30 days of request. (III)

65.8(2) The administrator shall be responsible for the implementation of procedures to support the policies established by the licensee. (III)

This rule is intended to implement Iowa Code section 135C.14.

481—65.9(135C) Personnel.

65.9(1) The personnel policies and procedures shall include the following requirements:

a. Written job descriptions for all employees or agreements for all consultants, which include duties and responsibilities, education, experience, or other requirements, and supervisory relationships; (III)

b. Annual performance evaluations of all employees and consultants which are dated and signed by the employee or consultant and the supervisor; (III)

c. Personnel records which are current, accurate, complete and confidential to the extent allowed by law. The record shall contain documentation of how the employee's or consultant's education and experience are relevant to the position for which they were hired; (III)

d. Roles, responsibilities, and limitation of student interns and volunteers; (III)

e. An orientation program for all newly hired employees and consultants which includes introduction to facility personnel policies and procedures and a discussion of the safety plan. Subparagraphs 65.9(1) "f"(3), (5) and (9) shall be included; (II, III)

f. A plan for a continuing education program with a minimum of 12 in-service programs per year. There shall be a written, individualized staff development plan implemented for each employee. The plan shall take into consideration the duties of the employee and the needs of the facility identified in the résumé of care. The plan shall ensure that each employee has the opportunity to develop and enhance skills and to broaden and increase knowledge needed to provide effective resident care including, but not limited to:

- (1) First aid; (II, III)
- (2) Human needs and behavior; (II, III)
- (3) Problems and needs of persons with mental illness; for example, diagnosis and treatment, suicide assessment and prevention; (II, III)
- (4) Medication; (II, III)
- (5) Crisis intervention; for example, use of restraints and seclusion; (II)
- (6) Delivery of services in accordance with the principles of normalization; (III)
- (7) Infection control and wellness; (III)

- (8) Fire safety, disaster, and tornado preparation; (II, III) and
- (9) Resident rights. (II, III)
- g.* Equal opportunity and affirmative action employment practices; (III)
- h.* Procedures to be used when disciplining an employee; (III) and
- i.* Appropriate dress and personal hygiene for staff and residents. (III)

65.9(2) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

- a.* Employees shall have a physical examination before employment and at least every four years after beginning employment. (III)
- b.* Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)
- c.* No one shall provide services in a facility if the person has a disease:
 - (1) Which is transmissible through required workplace contact; (I, II, III)
 - (2) Which presents a significant risk of infecting others; (I, II, III)
 - (3) Which presents a substantial possibility of harming others; (I, II, III)
 - (4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guideline for Infection Control in Hospital Personnel, 1998, Centers for Disease Control, U.S. Department of Health and Human Services, to determine (1), (2), (3) and (4).

d. There shall be written policies for emergency medical care for employees in case of sudden illness or accident. These policies shall include the administrative individuals to be contacted. (III)

e. Health certificates for all employees shall be available for review by the department. (III)

65.9(3) Staffing. The facility shall establish, subject to approval of the department, the numbers and qualifications of the staff required in an ICF/PMI using as its criteria the services being offered as indicated on the résumé of care and as required for implementation of individual program plans. (II, III)

a. Direct care staff. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. The policies and procedures shall provide for an on-call staff person to be available when residents and staff are absent from the facility. (II, III)

(1) The on-call staff person shall be designated in writing. (II, III)

(2) Residents or another responsible person shall be informed of how to contact the on-call person.

(II, III)

The staffing plan shall ensure that at least one qualified direct care staff person is on duty to carry out and implement the individual program plans. (II, III)

b. Qualified mental health professional. The ICF/PMI shall, by direct employment or contract, provide for sufficient services of a qualified mental health professional to attain or maintain the highest practicable mental and psychosocial well-being of each resident. Attainment shall be determined by resident assessment and individual plans of care. (I, II, III) Responsibilities of the QMHP shall include, but not be limited to:

(1) Approval of each resident's individual program plan; (II, III)

(2) Monitoring the implementation of each resident's individual program plan, including periodic personal contact; (II, III) and

(3) Participation on each resident's interdisciplinary team. (II, III)

c. Nursing staff. Each facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident. Attainment shall be determined by resident assessments and individual plans of care.

(1) The director of nursing (DON) shall be a registered nurse who is employed by the facility at least 40 hours per week. This person shall have two years' experience in direct care or supervision of people with mental illness. (II, III)

(2) The facility shall provide 24-hour service by licensed nurses, including at least one registered nurse on the day tour of duty, seven days a week. (II, III)

(3) If the DON has other institutional responsibilities, a qualified registered nurse shall serve as the DON's assistant so there is the equivalent of a full-time nursing supervisor on duty. (II, III)

(4) The department shall establish, on an individual facility basis, the numbers and qualifications of the staff required in the facility using as its criteria the services being offered as indicated on the résumé of care and as required for implementation of individual program plans. (II, III)

(5) The DON shall not serve as charge nurse in a facility with an average daily total occupancy of 60 or more residents. (II, III)

(6) A waived licensed practical nurse shall not be allowed as a charge nurse on any shift. (II, III)

(7) There shall be at least two people capable of rendering nursing service awake, dressed, and on duty at all times. (II, III)

d. Activity staff. Each ICF/PMI shall employ a recreational therapist, occupational therapist or activity coordinator to direct the activity program both inside and outside the facility in accordance with each resident's individual program plan. (III)

Staff for the activity program shall be based on the needs of the residents being served as identified on the IPP. (III)

(1) The activity program director shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. (III)

(2) Personnel coverage shall be provided when the activity program director is absent during scheduled activities. (III)

(3) The activity program director shall have access to all information about residents necessary to carry out the program. (III)

e. Responsibilities of the activity program director shall include:

(1) Coordinating all activities, including volunteer or auxiliary activities and religious services; (III)

(2) Ensuring that all records required are kept; (III)

(3) Coordinating the activity program with all other services in the facility; (III) and

(4) Participating in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

65.9(4) Personnel record. A personnel record shall be kept for each employee. (III)

a. The record shall include the employee's:

(1) Name and address, (III)

(2) Social security number, (III)

(3) Date of birth, (III)

(4) Date of employment, (III)

(5) References, (III)

(6) Position in the facility, (III)

(7) Job description, (III)

(8) Documentation of experience and education, (III)

(9) Staff development plan, (III)

(10) Annual performance evaluation, (II, III)

(11) Documentation of disciplinary action, (II, III)

(12) Date and reason for discharge or resignation, (III) and

(13) Current physical examination. (III)

b. The personnel records shall be made available to the long-term care resident's advocate/ombudsman of the department on aging in response to a complaint being investigated. (III)

65.9(5) Personnel histories.

a. Each health care facility shall submit a form specified by the department of public safety to the department of public safety, and receive the results of a criminal history check and dependent adult abuse record check before any person is employed in a health care facility. The health care facility may submit a form specified by the department of human services to the department of human services to request a child abuse history check. For the purposes of this subrule, "employed in a facility" shall be defined as any individual who is paid, either by the health care facility or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors), to provide direct or indirect treatment or services to residents in a health care facility. 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 requirements of this subrule are individuals such as building contractors, repair workers or others who are in a facility for a very limited purpose, are not in the facility on a regular basis, and who do not provide any treatment or services to the residents of the health care facility. (I, II, III)

b. A person who has a criminal record or founded dependent adult abuse report cannot be employed in a health care facility unless the department of human services has evaluated the crime or founded abuse report and concluded that the crime or founded abuse report does not merit prohibition from employment. (I, II, III)

c. Each health care facility shall ask each person seeking employment in a facility “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of crime in this state or any other state?” The person shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The person shall indicate, by signature, that the person has been informed that the record checks will be conducted. (I, II, III)

d. If a person has a record of founded child abuse in Iowa or any other state, the person shall not be employed in a health care facility unless the department of human services has evaluated the crime or founded report and concluded that the report does not merit prohibition of employment. (I, II, III)

e. Proof of dependent adult abuse and criminal history checks may be kept in files maintained by the temporary employee agencies and contractors. Facilities may require temporary agencies and contractors to provide a copy of the results of the dependent adult abuse and criminal history checks. (I, II, III)

This rule is intended to implement Iowa Code sections 135C.14(2) and 135C.14(6).
[ARC 0663C, IAB 4/3/13, effective 5/8/13]

481—65.10(135C) General admission policies. There shall be admission policies which address the following:

1. No resident shall be admitted or retained who is in need of greater services than the facility can provide. (II, III)

2. Residents shall be admitted only on a written order signed by a physician. (II, III)

3. A preplacement visit shall be completed prior to admission, except in case of an emergency admission or readmission, to familiarize the applicant with the facility and services offered. The policies and procedures may allow for waiving the requirement at the request of a person seeking admission when the completion of the visit would create a hardship for the person seeking admission. If the distance to be traveled makes it impossible to complete the visit in an eight-hour day, this may be considered to create a hardship. (III)

4. Prior to admission of an applicant, the facility shall obtain sufficient information to determine if its program is appropriate and adequate to meet the person’s needs. (III)

5. Admission criteria shall include, but not be limited to, age, sex, current diagnosis from an American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, substance abuse, dual diagnosis and criteria that are consistent with the résumé of care. (III)

6. Each facility shall maintain a waiting list with selection priorities identified. (III)

7. No ICF/PMI may admit more residents than the number of beds for which it is licensed. (II, III)

8. There shall be a written, organized orientation program for all residents which shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the health care, recovery, and rehabilitation of the individual and which shall be available for review by the department. (III)

9. Infants and children under the age of 18 shall not be admitted as residents to an ICF/PMI for adults unless given prior written approval by the department. A distinct part of an ICF/PMI, segregated from the adult section, may be established based on a résumé of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department’s review and approval. (III)

10. Within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A, the facility shall ask the resident or the resident's personal representative whether the resident is a veteran and shall document the response. If the facility determines that the resident is a potential veteran, the facility shall report the resident's name along with the names of the resident's spouse and any dependent children, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services.

If a resident is eligible for benefits through the United States Department of Veterans Affairs or other third-party payor, the facility first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care. (II, III)

This rule is intended to implement Iowa Code sections 135C.3 and 135C.23.

481—65.11(135C) Evaluation services. Each resident admitted shall have a physical examination and tuberculin test no more than 30 days before admission and a physical examination annually after that. Each annual examination shall be sufficient to ensure the resident has no physical condition which precludes living in the facility. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may meet this requirement. (II, III)

65.11(1) In addition to the required initial physical examination, each resident shall be evaluated to identify physical health, current level of functioning and the need for services. This evaluation shall be completed within 30 days of admission and annually after that. Information from other sources may be used in the evaluation if the information meets the requirements of subrules 65.11(2) and 65.11(3). (II, III)

65.11(2) The portion of the evaluation which describes the resident's physical health shall:

a. Identify current illnesses and disabilities and include recommendations for physical and physiological treatment and services; (II, III)

b. Include a description of the resident's ability for health maintenance; (II)

c. Include a mental status examination and history of mental health and treatments; (II, III) and

d. Be performed by a physician with a valid license to practice medicine and surgery, osteopathic medicine and surgery or osteopathy in Iowa. If the evaluation is not conducted in Iowa, it must be by a physician who holds a current license in the state in which the examination is performed. If the doctor is not a psychiatrist, a psychiatrist or health service provider in psychology licensed under Iowa Code section 154B.7 shall be consulted regarding the results of the mental status examination. (II, III)

65.11(3) The portion of the evaluation which describes the resident's current functioning level and need for services shall:

a. Identify the functioning level and need for services in self-care, community living skills, psychotherapeutic treatment, vocational skills, and academic skills as appropriate; (II, III)

b. Contain sufficient detail about skills and needs to determine appropriate placement; (II, III)

c. Be made without regard to the availability of services; (III) and

d. Be performed by a QMHP, consulting with an interdisciplinary team. (III)

65.11(4) Results of all evaluations shall be in writing and maintained in resident records. After the initial evaluation, all subsequent evaluations shall contain sufficient detail to determine changes in the resident's physical and mental health, skills, and need for services. (II, III)

65.11(5) A narrative social history shall be completed for each resident within 30 days of admission. The social history shall be completed and approved by the qualified mental health professional before the IPP is developed. (III)

a. When a social history is secured from another provider, the information shall be reviewed within 30 days of admission. The date of the review and a summary of significant changes in the information shall be entered in the resident's record. The social worker who reviews the history shall sign it. (III)

b. An annual review of the social history information shall be incorporated in the individual program plan progress notes. (III)

- c.* The social history shall address at least the following areas:
- (1) Referral source and reason for admission; (II, III)
 - (2) Legal status; (II, III)
 - (3) Previous living arrangements; (III)
 - (4) Services received previously and current service involvements; (II, III)
 - (5) Significant medical and mental health conditions including at least illnesses, hospitalizations, past and current drug therapy, and special diets; (II, III)
 - (6) Substance abuse history; (II, III)
 - (7) Work history; (III)
 - (8) Education history; (II)
 - (9) Relationship with family, significant others, and other support systems; (III)
 - (10) Cultural, ethnic and religious background; (II, III)
 - (11) Hobbies and leisure time activities; (III)
 - (12) Likes, dislikes, habits, and patterns of behavior; (II, III)
 - (13) History of aggressive or suicidal behavior; (I, II, III) and
 - (14) Impressions and recommendations. (II, III)
- This rule is intended to implement Iowa Code section 135C.14(7).

481—65.12(135C) Individual program plan (IPP). An initial program plan shall be developed within 24 hours of admission. This plan shall be based on information gained from the resident, family, physician or referring facility. Services to be provided shall be addressed. Intervention to be provided, if and when the need arises, shall also be addressed in the IPP. The plan shall be followed until the IPP required in subrule 65.12(1) is complete. The initial plan shall be completed by a registered nurse, a qualified social worker or a QMHP. (II, III)

65.12(1) An individual program plan for each resident shall be developed by an interdisciplinary team. The resident or the resident's legal guardian has the ultimate authority to accept or reject the plan unless otherwise determined by the court. The IPP shall be approved and have implementation monitored by the QMHP. (II, III)

a. The IPP shall be based on the individual service plan of the referring agency, if available, the information contained in the social history, the need for services identified in the evaluation, and any other pertinent information. (III)

b. The facility shall assist the resident in obtaining access to academic services, community living skills training, legal services, self-care training, support services, transportation, treatment, and vocational education as needed. These services may be provided by the facility or obtained from other providers. (III)

c. Services to the resident shall be provided in the least restrictive environment and shall incorporate the principle of normalization. (III)

d. If needed services are not available and accessible, the facility shall document the actions taken to locate and obtain those services. The documentation shall identify needs which will not be met because of the lack of available services. (III)

e. The IPP shall be developed within 30 days following admission to the facility and renewed at least annually. (II, III)

f. The IPP shall be written, dated, signed by the interdisciplinary team members, and maintained in the resident's record. (III)

g. Written notice of the meeting to develop an IPP shall be mailed or delivered to everyone included in the interdisciplinary team conference at least two weeks before the scheduled meeting. (III)

65.12(2) The IPP shall include the following:

- a.* Goals, (III)
- b.* Objectives, (III)
- c.* Specific services to be provided, (III)
- d.* People or agency responsible for providing services, (III)
- e.* Beginning date, (III) and

f. Anticipated duration of services. (III)

65.12(3) The IPP shall set out the procedure to be used to evaluate whether objectives are achieved. This procedure shall incorporate a process for ongoing review and revision. (III)

65.12(4) The interdisciplinary team shall review the IPP at a team meeting at least quarterly and when the resident's condition changes. (II, III)

a. The interdisciplinary team shall develop a written report which addresses:

- (1) The resident's progress toward objectives; (II, III)
- (2) The need for continued services; (II, III)
- (3) Recommendations concerning alternative services or living arrangements; (II, III) and
- (4) Any recommended change in guardianship, conservatorship or commitment status. (II, III)

b. The report shall reflect those involved in the review, the date of the review, and be maintained in the resident's record. (III)

65.12(5) There shall be procedures for recording the activities of each service provider and a mechanism to coordinate the activities of all service providers. Resident response to all activities shall be recorded. (III)

a. Staff shall create a record at the time of a service required by the IPP. If this is not possible, the record shall be written no more than seven days later. (III)

b. When the services are provided more than once a week, staff may make a monthly summarized entry in the resident's record. (III)

c. Entries shall be dated and signed by the person who provides the service. (III)

d. Entries shall be made when incidents occur. (III)

e. Entries shall be written in terms of behavioral observations and specific activities. Entries that involve subjective interpretations of a resident's behavior or progress shall be clearly identified and shall be supplemented with descriptions of behavior upon which the interpretation was based. (III)

This rule is intended to implement Iowa Code section 135C.14.

481—65.13(135C) Activity program. Each ICF/PMI shall have an organized activity program which is directed by a person qualified as required by 65.9(3) "d."

65.13(1) An activity program plan for the facility shall be based on needs identified in IPPs and on other interests expressed by residents. The activity program shall include leisure time management. (III)

65.13(2) Activities shall be offered at least daily during the daytime hours if residents are present, twice weekly in the evening and twice on the weekend. (III)

65.13(3) Activities offered shall be varied and shall be planned for individuals, small groups or large groups. (III)

65.13(4) Monthly calendars shall be prepared in advance and shall be kept for review by the department. Substitutions and cancellations shall be noted. (III)

65.13(5) Activities department personnel shall coordinate programs with other facility personnel. (III)

481—65.14(135C) Crisis intervention. There shall be written policies and procedures concerning crisis intervention. (II) These policies and procedures shall be:

1. Directed to maximizing the growth and development of the individual by incorporating a hierarchy of available alternative methods that emphasize positive approaches; (II, III)

2. Available in each program area and living unit; (II, III)

3. Available to individuals and their families; (II, III) and

4. Developed with the participation, as appropriate, of individuals served. (II, III)

65.14(1) Corporal punishment, physical abuse, and verbal abuse, for example, shouting, screaming, swearing, name calling, or any other activity which might damage an individual's self-respect shall be prohibited. All residents shall be treated with fairness and respect as required by rule 65.25(135C). (II)

65.14(2) Medication shall not be used as punishment, for the convenience of staff, or as a substitute for a program. Direct care staff shall monitor residents on medication and notify the physician if a resident is too sedated to participate in the IPP. (I, II)

481—65.15(135C) Restraint or seclusion. Physician's orders are required to use any kind of mechanical restraints or seclusion. (I, II, III) Restraints are defined as the following:

1. Type I is physical restraint which uses equipment to promote the safety of the individual. It is not applied directly to a person. Examples: divided doors and side rails.

2. Type II is mechanical restraint applied to someone's body. A device is applied to the body to promote safety of the individual. Examples: vests or soft tie devices, hand socks, geriatric chairs.

3. Type III is mechanical restraint applied to any part of the body which inhibits only the movement of that part of the body. Examples: wrist, ankle or leg restraints and waist straps.

65.15(1) Temporary restraint of residents shall be used only to prevent injury to the resident or to others. (I, II)

65.15(2) Temporary seclusion may be used:

a. To prevent injury to the resident or to others; (I, II)

b. To prevent serious disruption to the treatment program of other residents; (I, II)

c. To decrease stimulation which contributes to psychotic behavior; (I, II) and

d. When other interventions have failed. (I, II)

Restraint and seclusion shall not be used for punishment, for the convenience of staff, or as a substitution for supervision of program. Seclusion shall be used only in a department approved seclusion room. (I, II)

65.15(3) Restraints shall be stored in an area easily accessible to staff. (I, II, III) Type II and Type III restraints shall be specifically designed, manufactured, and customarily used to restrain individuals hospitalized in licensed psychiatric hospitals. Metal and plastic handcuffs, rope and makeshift devices are prohibited. (I, II)

65.15(4) Under no circumstances shall a resident be allowed to participate in the restraint of another resident. (I, II)

65.15(5) There shall be written policies that address the basic assumption and philosophy that govern the use of seclusion and physical and mechanical restraint. These shall:

a. Define the uses of seclusion and mechanical restraints; (III)

b. Designate staff who may authorize its use; (III)

c. Identify procedures to follow when implementing the policy which shall include provisions to ensure privacy and safety for restrained residents; (III) and

d. A written plan for treatment following the use of restraint or seclusion.

65.15(6) The physician and QMHP shall be notified immediately of the resident's need for placement in restraint or seclusion. An order for restraint or seclusion identifying the type, purpose and duration of use shall be obtained from the physician. If the resident is in seclusion longer than four hours, the physician and qualified mental health professional shall visit and evaluate the resident before the seclusion order is continued. If the resident is in restraint for two hours, the physician shall be called before the restraint order can be continued. If the resident is in restraint longer than four hours, the physician and QMHP shall visit and evaluate the resident before a restraint order is continued. Standing or PRN orders for seclusion or restraint are prohibited. (I, II)

65.15(7) If a resident is restrained with Type II or Type III restraints for 6 hours or secluded for 12 hours in a 24-hour period; or if the resident is secluded or restrained with Type II or Type III restraints for any amount of time in three consecutive 24-hour periods, the physician and QMHP shall visit the resident and assess the resident's need for a higher level of care. If the need for restraint or seclusion continues, the resident shall be transferred to an acute level of care. (I, II)

65.15(8) During any period of mechanical restraint or seclusion, the facility shall provide for the emotional and physical needs of the resident. (I, II)

65.15(9) The resident shall be informed of the reason for seclusion and restraint and conditions for release. The resident's guardian shall be notified when Type II or Type III restraints or seclusion is used. The facility shall also notify the resident's family or other significant person if the resident has previously signed a form granting consent to do so. (I, II, III)

65.15(10) Each resident's record shall contain all information about restraints or seclusion. The administrator shall maintain a daily record of seclusion use. This record shall be available for review by the department. (II, III)

Documentation of each incident of restraint or seclusion shall include at least:

- a. Clinical assessment before the resident is secluded or restrained; (I, II)
- b. Circumstances that led to seclusion or restraint; (I, II)
- c. Explanation of less restrictive measures used before restraint or seclusion; (I, II)
- d. Physician's order; (I, II)
- e. Visual observation of the resident every 15 minutes, or more frequently if needed, to monitor general well-being including respirations, circulation, positioning and alertness as indicated; (I, II)
- f. Description of the resident's activity at the time of observation to include verbal exchange and behavior; (I, II)
- g. Description of safety procedures taken (removal of dangerous objects, etc.); (I, II)
- h. Vital signs, including blood pressure, pulse and respiration unless contraindicated by resident behavior and reasons documented; (I, II)
- i. Release of each mechanical restraint and exercise and massage every two hours; (I, II, III)
- j. Record of intake of food and fluid; (I, II, III)
- k. Use of toilet; (II, III) and
- l. Number of hours and minutes in seclusion. (II, III)

65.15(11) The facility shall educate staff on restraint and seclusion theory and techniques. The training shall be conducted by people with experience and documented education in the appropriate use of restraint and seclusion. (II, III)

- a. The facility shall keep a record of the training for review by the department and shall include attendance. (II, III)
- b. Only staff who have documented training in restraint and seclusion theory and techniques shall be authorized to assist with seclusion or restraint of a resident. (I, II, III)

65.15(12) The facility shall maintain a record of the hours and minutes of each type of restraint and seclusion used on a monthly basis.

481—65.16(135C) Discharge or transfer. Procedures for the discharge or transfer of the resident shall be established and followed. (II, III)

65.16(1) Discharge plan. The decision to discharge a person and the plan for doing so shall be established through the participation of the resident, members of the interdisciplinary team and other resource personnel as appropriate for the welfare of the individual. (II, III)

- a. Discharge planning shall begin within 30 days of admission and be carried out in accordance with the IPP. (II, III)
- b. As changes occur in a resident's physical or mental condition necessitating services or care which cannot be adequately provided by the facility, the resident shall be transferred promptly to another appropriate facility pursuant to subrule 65.10(1). (II, III)
- c. Notification shall be made to the next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)
- d. Proper arrangements shall be made for the welfare of the resident prior to the transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)
- e. The licensee shall not refuse to discharge or transfer a resident when directed by the physician, resident, legal representative, or court. (II, III)
- f. Advanced notification by telephone shall be made to the receiving facility prior to the transfer of any resident. (III)
- g. When a resident is transferred or discharged, the current evaluation and treatment plan and progress notes for the last 30 days, as set forth in these rules, shall accompany the resident. (II, III)
- h. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

i. A discharge or transfer authorization and summary shall be prepared for each resident who has been discharged or transferred from the facility. It shall be disseminated to appropriate persons to ensure continuity of care and in accordance with the requirements to ensure confidentiality. (II, III)

j. A transfer to a part of a facility that has a different license must be handled the same way as a transfer to another facility, and not as an intrafacility transfer. (II, III)

65.16(2) Intrafacility transfer. Residents shall not be arbitrarily moved from room to room within a health care facility. (II, III)

a. Involuntary relocation may occur only to implement goals and objectives in the IPP and in the following situations:

(1) Incompatibility with or behavior disturbing to roommates, as documented in the residents' records; (I, II)

(2) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex; (II, III)

(3) Reasonable and necessary administrative decisions regarding the use and functioning of the building. (II, III)

b. Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident or legal guardian include:

(1) Punishment or behavior modification; (II) and

(2) Discrimination on the basis of race or religion. (II, III)

c. If intrafacility relocation is necessary for reasons outlined in paragraph "*a*," the resident shall be notified at least 48 hours prior to the transfer and the reason shall be explained. The legal guardian shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or legal guardian within seven days unless documentation indicates that it was not possible to contact the legal guardian or obtain their signature. (II, III)

d. If emergency relocation is required to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be documented. The family and legal guardian shall be notified immediately, or as soon as possible, of the condition requiring emergency relocation, and the notification shall be documented. (II, III)

65.16(3) Involuntary discharge or transfer—reasons. Residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C which states that a resident shall be transferred or discharged only for the following:

a. Medical reasons which include:

(1) Acute stage of alcoholism, mental illness, or an active state of a communicable disease; (I, II) or

(2) Need for medical procedures as determined by a physician, or services which cannot be or are not being carried out in the facility; (I, II)

b. Resident's welfare or welfare of other residents which includes residents who are dangerous to themselves or other residents; (I) or

c. Nonpayment except as prohibited by Medicaid. (II)

65.16(4) Involuntary transfer or discharge—written notice. Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or responsible party at least 30 days in advance of the proposed transfer or discharge. (II) The 30-day requirement shall not apply in any of the following instances:

a. If an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and written medical justification of the attending physician. Emergency transfers or discharges may also be mandated to protect the health, safety, or well-being of other residents and staff. (I, II)

b. If the transfer or discharge is subsequently agreed to by the resident or by the resident's legal guardian, and notification is given to the legal guardian, physician, and the person or agency responsible for the resident's placement, maintenance and care in the facility. (II)

65.16(5) Contents of notice. The notice required by 65.16(4) shall contain all of the following information:

- a. The stated reason for the proposed transfer or discharge. (II)
- b. The effective date of the proposed transfer or discharge. (II)
- c. The following statement must be included:

“You have a right to appeal the facility’s decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa department of inspections and appeals (hereinafter referred to as “department”) within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department and you will not be transferred prior to a final decision. Provision may be made for extension of the 14-day requirement upon request to the department designee in emergency circumstances. If you lose the hearing, you will not be transferred before the expiration date of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than 5 days following final decision of such hearing. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Iowa Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083.” (II)

65.16(6) Stay of transfer or discharge. A request for a hearing made under 65.16(5) “c” shall stay a transfer or discharge pending a hearing or appeal decision. (II)

a. The type of hearing determined by a representative of the department. Notice of the date, time, and place of the hearing shall be sent by United States mail or delivered in person to the licensee, resident, legal guardian, and Iowa department on aging’s long-term care resident’s advocate/ombudsman of record not later than five full business days after receipt of the request. This notice shall also inform the licensee, resident, and legal guardian that they have a right to appear at the hearing in person or be represented by their attorneys or other individuals. The hearing shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present. The Iowa department on aging’s long-term care resident’s advocate/ombudsman shall have the right to appear at the hearing. (II)

b. The hearing shall be heard by a department of inspections and appeals administrative law judge pursuant to department rules. The licensee or designee shall have the opportunity to present oral testimony or written materials to show by a preponderance of the evidence just cause why a transfer or discharge may be made. The resident and legal guardian shall also have an opportunity to present oral testimony or written material to show just cause why a transfer or discharge should not be made; the burden of proof rests on the party requesting the transfer or discharge. (II)

c. Based upon all testimony and materials submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact, conclusions of law, and issue a decision and order. This decision shall be mailed by regular mail to the licensee, resident, legal guardian, and department on aging’s long-term care resident’s advocate/ombudsman within ten working days after the hearing has been concluded. (II)

d. Based upon all testimony and material submitted to the representative of the department, the representative shall issue, in accordance with Iowa Code chapter 17A, written findings of fact and conclusions of law and issue a decision and order in respect to the adverse action. This decision shall be mailed by certified mail to the licensee, resident, responsible party, and department on aging’s long-term care resident’s advocate/ombudsman within 10 working days after the hearing has been concluded. The representative shall have the power to issue fines and citations against the facility in appropriate circumstances.

A request for review of a proposed decision in which the department is the final decision maker shall be made within 15 days of issuance of the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews a proposed decision upon its own motion within 15 days of the issuance of the decision. (II)

e. A copy of the notice required by 65.16(4) shall be personally delivered to the resident by the licensed facility and a copy placed in the resident's record. A copy shall also be transmitted to the department, the resident's legal guardian, physician, the person or agency responsible for the resident's placement, maintenance, and care in the facility, and the department on aging's long-term care resident's advocate/ombudsman. (II)

f. If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

g. The involuntary transfer or discharge shall be discussed with the resident, legal guardian, and the person or agency responsible for the resident's placement, maintenance, and care in the facility within 48 hours after notice of discharge has been received. The explanation and discussion of the reasons for involuntary transfer or discharge shall be given by the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and shall be made a part of the resident's record. (II)

h. The resident shall receive counseling services before (by the sending facility) and after (by the receiving facility) the involuntary transfer to minimize the possible adverse effects of the involuntary transfer. Counseling shall be documented in the resident's record. Counseling shall be provided by a qualified individual who meets one of the following criteria:

- (1) Has a bachelor's or master's degree in social work from an accredited college; (II)
- (2) Is a graduate of an accredited four-year college and has had at least one year of full-time paid employment in a social work capacity with a public or private agency; (II)
- (3) Has been employed in a social work capacity for a minimum of four years in a public or private agency; (II) or
- (4) Is a licensed psychologist or psychiatrist. (II)

i. The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be discharged or transferred. (II)

j. The receiving health care facility of a resident involuntarily discharged or transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

k. In the case of an emergency transfer or discharge as outlined in 65.16(4) "b," the resident must still be given a written notice prior to or within 48 hours following transfer or discharge. A copy of this notice must be placed in the resident's file and it must contain all the information required by 65.16(5). In addition, the notice must contain a statement in not less than 12-point type, which reads:

"You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Iowa department of inspections and appeals (hereinafter referred to as "department") within seven days after receiving this notice. You have the right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after receipt of your request by the department. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115 or you may write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083."

A hearing requested pursuant to this subrule shall be held in accordance with 65.16(6) "a," "b" and "c." (II)

l. Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility's license by the department. In the case of a facility voluntarily closing, a period of 30 days must be allowed for an orderly transfer of residents to other facilities. (II)

This rule is intended to implement Iowa Code sections 135C.14(8), 135C.31, 135C.43, and 135C.46.

481—65.17(135C) Medication management. Medications shall be prescribed on an individual basis by a person who is authorized by Iowa law to prescribe. (I, II)

1. Medication orders shall be correctly implemented by qualified personnel. (II)

2. Qualified staff shall ensure that residents are able to take their own medication. (I, II)

3. Each physician order allowing a resident to self-administer medications shall specify whether this self-medication shall be without supervision or under the supervision of qualified staff as defined in 65.17(2). (I, II)

65.17(1) A properly trained person shall be charged with the responsibility of administering nonparenteral medications.

a. The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

b. This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

c. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved nurse aide course, nurse aide training and testing program or nurse aide competency examination.

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

d. A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration;

(4) Successfully complete a department-approved nurse aide competency evaluation.

e. A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

The requirements of paragraph "c" of this subrule do not apply to this individual.

f. Unit dose medication shall remain in the identifiable unit dose package until given to the resident. (II)

g. Medications that are not contained in unit dose packaging shall be set up, identified by resident name and medication name, and administered by the same person. The medications shall be administered within one hour of preparation. (II)

h. The person administering medications must observe and check to make sure the resident swallows oral medications and must record the date, time, amount and name of each medication given. (II)

i. Injectable medications shall not be administered by anyone other than a prescriber or licensed nurse except when residents have been certified by a physician as capable of taking their insulin. When a resident has been certified as capable of taking insulin, the resident may prepare and inject the insulin. (II)

j. Current and accurate records must be kept on the receipt and disposition of all Schedule II drugs. (II, III)

65.17(2) For each resident who is taking medication with or without supervision, there shall be documentation on the individual's record to include:

a. Name of resident; (II, III)

- b.* Name of drug, dose, and schedule; (II, III)
- c.* Method of administration; (II, III)
- d.* Identified drug allergies and observed adverse reactions; (I, II)
- e.* Special precautions for that resident; (I, II) and
- f.* Documentation of resident's continuing ability to administer own medication. (I, II)

65.17(3) Medication counseling shall be provided for all residents in accordance with the IPP on an ongoing basis and as part of discharge planning unless contraindicated in writing by the physician with reasons and pursuant to 65.12(2) "c." (II, III)

Each resident and when appropriate, a family member or other identified caregiver, shall be given verbal and written information about all medications the resident is currently using, including over-the-counter medications. A suggested reference is "USPDI, Advice for the Patient." (II, III)

The information shall include:

- a.* Name, reason for, and amount of medication to be taken; (II)
- b.* Time medication is to be taken and reason that the schedule was established; (II)
- c.* Possible benefits, risks and side effects of each medication, including over-the-counter medications; (II)
- d.* A list of resources in the community qualified to answer questions about medications; (II, III) and
- e.* A list of available resources or agencies which may assist the resident to obtain medication after discharge. (III)

65.17(4) Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in a secure centralized location. Individual locked storage shall be utilized. (II, III)

a. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

- (1) Adequate size cabinet with lock which can be used for storage of drugs, solutions, and prescriptions. A locked drug cart may be used. (II, III)
- (2) A bathroom shall not be used for drug storage. (II, III)
- (3) The drug storage cabinet shall be kept locked when not in use. (II, III)
- (4) The drug storage cabinet key shall be in the possession of the employee charged with the responsibility of administering medication. (II, III)
- (5) Medications requiring refrigeration which are stored in a common refrigerator shall be kept in a locked box properly labeled, and separated from food and other items. (II, III)
- (6) Drugs for external use shall be stored separately from drugs for internal use. External medications are those to be applied to the outside of the body and include, but are not limited to, salves, ointments, gels, paste, soaps, baths, and lotions. Internal medications are those to be applied inside the body or ingested and include, but are not limited to, oral and injectable medications, eye drops and ointments, ear drops and ointments, and suppositories. Also, eye drops and ear drops shall be separated from each other as well as from other internal and external medications. (II, III)
- (7) All potent, poisonous, or caustic materials shall be stored in a separate room from the medications. (II, III)
- (8) Inspection of the condition of stored drugs shall be made by the administrator and a licensed pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but need not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current order, and drugs improperly stored. (III)
- (9) Double-locked storage of Schedule II drugs shall not be required under single unit package drug distribution systems in which the quantity stored does not exceed a seven-day supply and a missing dose can be readily detected but must be kept in a locked medication cabinet. Quantities in excess of a seven-day supply must be double-locked. (II)

- b.* Bulk supplies of prescription drugs shall not be kept. (III)

65.17(5) All labels on medications must be legible. If labels are not legible, the medication shall be sent back to the dispenser as defined in Iowa Code section 147.107 for relabeling. (II, III)

a. The medication for each resident shall be kept or stored in the original dispensed containers. (II, III)

b. The facility shall adopt policies and procedures to destroy unused prescription drugs for residents who die. The policies and procedures shall include, but not be limited to, the following:

(1) Drugs shall be destroyed by the person in charge in the presence of the administrator or the administrator's designee or, if a unit dose system is used, the drugs shall be returned to the supplying pharmacist; (III)

(2) Notation of the destruction shall be made in the resident's chart, with signatures of the persons involved in the destruction; (III)

(3) The manner in which the drugs are disposed of shall be identified (i.e., incinerator, sewer, landfill). (II, III)

c. Reserved.

d. The facility shall also adopt policies and procedures for the disposal of controlled substances as defined by the Iowa board of pharmacy dispensed to residents whose administration has been discontinued by the prescriber. These policies and procedures shall include, but not be limited to, the following:

(1) Procedures for obtaining a release from the resident; (II, III)

(2) The manner in which the drugs were destroyed and by whom, including witnesses to the destruction; (II, III)

(3) Mechanisms for recording the destruction; (II, III)

(4) Procedures to be used when the resident or the conservator or guardian refuses to grant permission for destruction. (II, III)

e. The facility shall adopt policies and procedures for the disposal of unused, discontinued medication. The procedures shall include, but not be limited to:

(1) A specified time after which medication must be destroyed, sent back to the dispenser or placed in long-term storage; (II, III)

(2) Procedures for obtaining permission of the resident, or the conservator or guardian; (II, III)

(3) Procedures to be used when the resident, conservator or guardian refuses to grant permission for disposal; (II, III)

(4) Unused, discontinued medication shall be locked and shall be separate from current medication. (II, III)

f. Reserved.

g. Residents shall not keep any prescription or over-the-counter medication in their possession unless the resident has been determined to be capable of self-administration of medications. (I, II, III)

h. No prescription drugs shall be administered to a resident without a written order signed by a person qualified to prescribe the medication and renewed quarterly. (II)

i. Prescription drugs shall be reordered only with the permission of the attending prescriber. (II, III)

j. No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

65.17(6) Each facility shall establish policies and procedures to govern the administration of prescribed medications to residents on leave from the facility. (III)

a. Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident's name, the facility, the medication, its strength, dose, and time of administration. (II, III)

b. Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners. (II, III)

c. Medication distributed as described in this subrule may be issued only by facility personnel responsible for administering medication. (II, III)

65.17(7) Each ICF/PMI that administers controlled substances shall annually obtain a registration from the Iowa board of pharmacy examiners pursuant to Iowa Code section 204.302(1). (III)

This rule is intended to implement Iowa Code section 135C.14.

481—65.18(135C) Resident property and personal affairs. The admission of a resident does not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal guardian. (II, III)

65.18(1) The admission of a resident shall not grant the ICF/PMI the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the resident's safety and for safe and orderly management of the facility as required by these rules and in accordance with the IPP. (III)

65.18(2) An ICF/PMI shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

65.18(3) Residents' funds held by the ICF/PMI shall be in a trust account and kept separate from funds of the facility. (III)

65.18(4) No administrator, employee or their representative shall act as guardian, trustee, or conservator for any resident or the resident's property, unless the resident is related to the person acting as guardian within the third degree of consanguinity. (III)

65.18(5) If a facility is a county care facility, upon the verified petition of the county board of supervisors, the district court may appoint, without fee, the administrator of a county care facility as conservator or guardian, or both, of a resident of such a county care facility. The administrator may establish either separate or common bank accounts for cash funds of these residents. (III)

This rule is intended to implement Iowa Code section 135C.24.

481—65.19(135C) Financial affairs. Residents who have not been assigned a guardian or conservator by the court may manage their personal financial affairs, and to the extent, under written authorization by the residents that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

65.19(1) *Written account of resident funds.* The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

a. An employee shall be designated in writing to be responsible for resident accounts. (II)

b. The facility shall keep on deposit personal funds over which the resident has control when requested by the resident. (II)

c. If the resident requests these funds, they shall be given to the resident with a receipt maintained by the facility and a copy to the resident. If a conservator or guardian has been appointed for the resident, the conservator or guardian shall designate the method of disbursing the resident's funds. (II)

d. If the facility makes a financial transaction on a resident's behalf, the resident or the resident's legal guardian or conservator must receive or acknowledge having seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

65.19(2) *Contracts.* There shall be a written contract between the facility and each resident which meets the following requirements:

a. States the base rate or scale per day or per month, the services included, and the method of payment; (III)

b. Contains a complete schedule of all offered services for which a fee may be charged in addition to the base rate; (III)

c. Stipulates that no further additional fees shall be charged for items not contained in complete schedule of services listed in this subrule; (III)

d. States the method of payment of additional charges; (III)

e. Contains an explanation of the method of assessment of additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

f. States that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.; (III)

g. Contains an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on the program assessment at the time of admission, which is determined in consultation with the administrator; (III)

h. Includes the total fee to be charged initially to the specific resident; (III)

i. States the conditions whereby the facility may make adjustments to its overall fees for residential care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

(1) Written notification to the resident and responsible party, when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to the effective date of changes; (III)

(2) Notification to the resident and payer, when appropriate, of changes in additional charges based on a change in the resident's condition. Notification must occur prior to the date the revised additional charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III) and

(3) The terms of agreement in regard to refund of all advance payments, in the event of transfer, death, or voluntary or involuntary discharge; (III)

j. States the terms of agreement concerning holding and charging for a bed in the event of temporary absence of the resident, which terms shall include, at a minimum, the following provisions:

(1) If a resident has a temporary absence from a facility for medical treatment, the facility shall hold the bed open and shall receive payment for the absent period in accordance with provisions of the contract between the resident or the legal guardian and the facility. (II)

(2) If a resident has a temporary absence from a facility in accordance with the IPP, the facility shall ask the resident and payer if they wish the bed held open. This shall be documented in the resident's record including the response. The bed shall be held open and the facility shall receive payment for the absent periods in accordance with the provisions of the contract between the resident or the legal guardian and the facility. (II)

k. States the conditions under which the involuntary discharge or transfer of a resident would be affected; (III)

l. States the conditions of voluntary discharge or transfer; (III) and

m. Sets forth any other matters deemed appropriate by the parties to the contract. No contract or any provision shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter. (III)

65.19(3) *Contract—copy to party.* Each party shall receive a copy of the signed contract. (III)

65.19(4) The contract shall state the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's legal representative.

a. The facility shall ask the resident or legal representative if they want the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

b. The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

This rule is intended to implement Iowa Code sections 135C.23(1) and 135C.24.

481—65.20(135C) Records.

65.20(1) *Resident record.* The licensee shall keep a permanent record about each resident with all entries current, dated, and signed. (II) The record shall include:

a. Name and previous address of resident; (III)

- b. Birth date, sex, and marital status of resident; (III)
- c. Church affiliation; (III)
- d. Physician's name, telephone number, and address; (III)
- e. Dentist's name, telephone number, and address; (III)
- f. Name, address and telephone number of next of kin or legal representative; (III)
- g. Name, address and telephone number of the person to be notified in case of emergency; (III)
- h. Funeral director, telephone number, and address; (III)
- i. Pharmacy name, telephone number, and address; (III)
- j. Results of evaluation pursuant to rule 481—65.11(135C); (III)
- k. Certification by the physician that the resident requires no higher level of care than the facility is licensed to provide; (III)
- l. Physician's orders for medication and treatments in writing, signed by the physician quarterly and diet orders renewed yearly; (III)
- m. A notation of yearly or other visits to physician or other professionals, all consultation reports and progress notes; (III)
- n. Any change in the resident's condition; (II, III)
- o. A notation describing the resident's condition on admission, transfer, and discharge; (III)
- p. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)
- q. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)
- r. Disposition of personal property; (III)
- s. Copy of IPP pursuant to subrule 65.12(1); (III) and
- t. Progress notes pursuant to subrules 65.12(4) and 65.12(5). (III)

65.20(2) Confidentiality of resident records. The facility shall have policies and procedures providing that each resident shall be ensured confidential treatment of all information, including information contained in an automatic data bank. The resident's or the resident's legal guardian's written informed consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

A release of information form shall be used which includes to whom the information shall be released, the reason for the information being released, how the information is to be used, and the period of time for which the release is in effect. A third party, not requesting the release, shall witness the signing of the release of information form. (II)

a. The facility shall limit access to any resident records to staff and consultants providing professional service to the resident. Information shall be made available to staff only to the extent that the information is relevant to the staff person's responsibilities and duties. (II)

Only those personnel concerned with financial affairs of the residents may have access to the financial information. This is not meant to preclude access by representatives of state or federal regulatory agencies. (II)

b. The resident, or the resident's legal guardian, shall be entitled to examine all information and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician or QMHP determines the disclosure of the record or section is contraindicated in which case this information will be deleted prior to making the record available to the resident. This determination and the reasons for it must be documented in the resident's record by the physician or qualified mental health professional in collaboration with the resident's interdisciplinary team. (II)

65.20(3) Incident records. Each ICF/PMI shall maintain an incident record report and shall have available incident report forms. (II, III)

- a. The report of every incident shall be in detail on a printed incident report form. (II, III)
- b. The person in charge at the time of the incident shall oversee the preparation and sign the report. (III)

c. A copy of the incident report shall be kept on file in the facility available for review and a part of administrative records. (III)

65.20(4) Retention of records. Records shall be retained in the facility for five years following termination of services to the resident even when there is a change of ownership. (III)

When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

This rule is intended to implement Iowa Code section 135C.24.

481—65.21(135C) Health and safety.

65.21(1) Physician. Each resident shall have a designated licensed physician who may be called when needed. (III)

65.21(2) Emergency care. Each facility shall have written policies and procedures for emergency medical or psychiatric care to include:

a. A written agreement with a hospital or psychiatric facility or documentation of attempt to obtain a written agreement for the timely admission of a resident who, in the opinion of the attending physician, requires inpatient services; (II, III)

b. Provisions consistent with Iowa Code chapter 229; (II, III) and

c. Immediate notification by the person in charge to the physician or QMHP, as appropriate, of any accident, injury or adverse change in the resident's condition. (I, II)

65.21(3) First-aid kit. A first-aid emergency kit shall be available on each floor in every facility. (II, III)

65.21(4) Infection control. Each facility shall have a written and implemented infection control program addressing the following:

a. Techniques for hand washing consistent with Guidelines for Handwashing and Hospital Control, 1985, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923404; (I, II, III)

b. Techniques for handling of blood, body fluids, and body wastes consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

c. Decubitus care; (I, II, III)

d. Infection identification; (I, II, III)

e. Resident care procedures to be used when there is an infection present consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

f. Sanitation techniques for resident care equipment; (I, II, III)

g. Techniques for sanitary use and reuse of enteral feeding bags, feeding syringes and urine collection bags; (I, II, III)

h. Techniques for use and disposal of needles, syringes, and other sharp instruments consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III) and

i. Aseptic techniques when using:

(1) Intravenous or central line catheter consistent with Guideline for Prevention of Intravascular Device Related Infections, Centers for Disease Control, U.S. Department of Health and Human Services, PB97-130074, (I, II, III)

(2) Urinary catheter, (I, II, III)

(3) Respiratory suction, oxygen or humidification, (I, II, III)

(4) Dressings, soaks, or packs, (I, II, III)

(5) Tracheostomy, (I, II, III)

(6) Nasogastric or gastrostomy tubes, (I, II, III)

(7) Sanitary use and reuse of feeding syringes and single-resident uses and reuse of urine collection bags. (I, II, III)

CDC Guidelines may be obtained from the U.S. Department of Commerce, Technology Administration, National Technical Information Service, 5285 Port Royal Rd., Springfield, Virginia 22161 (1-800-553-6847).

65.21(5) Disposable items. There shall be disposable or one-time use items available with provisions for proper disposal to prevent reuse except as allowed by 65.21(4)“g.”

65.21(6) Infection control committee. Each facility shall establish an infection control committee of representative professional staff responsible for overall infection control in the facility. (III)

a. The committee shall annually review and revise the infection control policies and procedures to monitor effectiveness and suggest improvement. (III)

b. The committee shall meet at least quarterly, submit reports to the administrator, and maintain minutes in sufficient detail to document its proceedings and actions. (III)

c. The committee shall monitor the health aspect and the environment of the facility. (III)

These rules are intended to implement Iowa Code sections 135C.14(3), 135C.14(5) and 135C.14(8).

65.21(7) Dental services. The facility shall assist residents to obtain regular and emergency dental services and provide necessary transportation. Dental services shall be performed only on the request of the resident or legal guardian. The resident’s physician shall be advised of the resident’s dental problems. (III)

65.21(8) Safe environment. The licensee of an ICF/PMI is responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II) The ICF/PMI may have locked exit doors and shall meet the fire and safety rules and regulations as promulgated by the state fire marshal. (I, II)

65.21(9) Disaster. The licensee shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (II, III)

a. The plan shall be posted. (II, III)

b. Training shall be provided to ensure that all employees and residents are knowledgeable of the emergency plan. The training shall be documented. (II, III)

c. Residents shall be permitted to smoke only in posted areas where proper facilities are provided. Smoking by residents considered to be careless shall be prohibited except under direct supervision and in accordance with the IPP. (II, III)

65.21(10) Safety precautions. The facility shall take reasonable measures to ensure the safety of residents and shall involve the residents in learning the safe handling of household supplies and equipment in accordance with the policies and procedures established by the facility. (II)

All potent, poisonous, or caustic materials shall be plainly labeled and stored in a specific locked, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons. (I, II)

65.21(11) Hazards. Entrances, exits, steps, and outside steps and walkways shall be cleared of ice and snow as soon as possible, and kept free of other hazards. (II, III)

65.21(12) Laundry. All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

a. Except for related activities, the laundry room shall not be used for other purposes. (III)

b. Personal laundry shall be marked with an identification unless the residents are responsible for doing their own laundry as indicated in the individual program plan. (III)

c. There shall be an adequate supply of clean, stain-free linens so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

d. Each bed shall be provided with clean, stain-free washable bedspreads and sufficient lightweight serviceable blankets. A complete change of bed linens shall be available for each bed. Linens on beds shall be clean, stain-free and in good repair at all times. (III)

65.21(13) Supplies, equipment, and storage. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. These may include: books (standard and large print), magazines, newspapers, radio, television, bulletin boards, board games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, and outdoor equipment. Supplies and equipment shall be appropriate to the chronological age of the residents. (III)

Storage shall be provided for recreational equipment and supplies. (III)
This rule is intended to implement Iowa Code section 135C.14(1).

481—65.22(135C) Nutrition. There shall be policies and procedures written and implemented for dietary staffing.

1. The person responsible for planning menus and monitoring the kitchens in each facility shall have completed training, approved by the department, in sanitation and food preparation. (III)

2. In facilities licensed for over 15 beds, food service personnel shall be on duty during a 12-hour span extending from the preparation of breakfast through supper. (III)

3. There shall be written work schedules and time schedules covering each type of job in the food service department for facilities over 15 beds. These work and time schedules shall be posted or kept in a notebook which is available for use in the food service area. (III)

65.22(1) Nutrition and menu planning. Residents shall be encouraged to the maximum extent possible to participate in meal planning, shopping, and in preparing and serving the meal and cleaning up. The facility shall be responsible for helping residents become knowledgeable of what constitutes a nutritionally adequate diet. (III)

a. Menus shall be planned and served to meet nutritional needs of residents in accordance with the physician's diet orders which shall be renewed yearly. Menus shall be planned and served to include foods and amounts necessary to meet the recommended daily dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. Other foods shall be included to meet energy requirements (calories) to add to the total nutrients and variety of meals. (II, III)

b. At least three meals or their equivalent shall be made available to each resident daily, consistent with those times normally existing in the community. (II, III)

(1) There shall be no more than a 14-hour span between the substantial evening meal and breakfast. (III)

(2) To the extent medically possible, bedtime nourishments, containing a protein source, shall be offered routinely to all residents. Special nourishments shall be available when ordered by the physician. (II, III)

c. Menus shall include a variety of foods prepared in various ways. The same menus shall not be repeated on the same day of the following week. (III)

d. If modified diets are ordered by the physician, the person responsible for writing the menus shall have completed department-approved training in simple therapeutic diets. A copy of a modified diet manual approved by the department and written within the past five years shall be available in the facility. (II, III)

e. Therapeutic diets shall be served accurately. (II, III)

f. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing, and serving food. (III)

g. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

h. A file of tested recipes adjusted to the number of people to be fed in the facility shall be maintained. (III)

65.22(2) Dietary storage, food preparation, service. In each stage, food shall be handled with maximum care for safety and good health.

a. The use of foods from salvaged, damaged, or unlabeled containers is prohibited. (II, III)

b. No perishable food shall be allowed to stand at room temperature any longer than is required to prepare and serve. (II, III)

c. Canning food is prohibited. The facility may freeze fruits, vegetables, and meats provided strict sanitary procedures are followed and in accordance with recommendations in the "Food Service Sanitation Manual," revised 1976, U.S. Department of Health, Education, and Welfare, Public Health Service, U.S. Government Printing Office, Washington, D.C. (II)

d. Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a three-day period shall be maintained on the premises. (III)

e. If family-style service is used, all leftover prepared food that has been on the table shall be safely handled. (III)

f. Poisonous compounds shall not be kept in food storage or preparation areas except for a sanitizing agent which shall be kept in a locked cabinet. (II, III)

65.22(3) Sanitation in food preparation area. The facility shall develop and implement policies and procedures to address sanitation, meal preparation and service in accordance with recommendations in the "Food Service Sanitation Manual" reference in 65.22(2)"c," which shall be used as the established, nationally recognized reference for establishing and determining satisfactory compliance with the department's food service and sanitation rules. (III)

a. In facilities of 15 beds or fewer, residents may be allowed in the food preparation area in accordance with their IPP. (III)

b. In facilities licensed for over 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)

c. All appliances and work areas shall be kept clean and sanitary. (III)

d. There shall be written procedures established for cleaning all work and serving areas in facilities over 15 beds and a schedule of duties to be performed daily shall be posted in each food area. (III)

e. The food service area shall be located so it will not be used as a passageway by residents, guests, or nonfood service staff in facilities over 15 beds. (III)

f. Dirty linen shall not be carried through the food service area unless it is in sealed, leakproof containers. (III)

g. Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

65.22(4) Hygiene of food service personnel. If food service employees are assigned duties outside the dietetic service, these duties shall not interfere with sanitation, safety, or time required for dietetic work assignments. (II, III)

a. Employees shall wear clean, washable uniforms that are not used for duties outside the food service area in facilities over 15 beds. (III)

b. Hair nets shall be worn by all food service personnel and residents who do work in the kitchen in facilities over 15 beds and effective hair restraints in facilities with fewer than 15 beds. (III)

c. People who handle food shall use correct hand-washing and food-handling techniques as identified in the "Food Service Sanitation Manual." People who handle dirty dishes shall not handle clean dishes without washing their hands. (III)

This rule is intended to implement Iowa Code section 135C.14.

481—65.23(135C) Physical facilities and maintenance.

65.23(1) Housekeeping. The facility shall have written procedures for daily and weekly cleaning (III) which include, but need not be limited to:

a. All rooms including furnishings, all corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment or accumulations of refuse. (III)

b. All resident bedrooms, including furnishings, shall be cleaned and sanitized before use by another resident. (III)

c. Polishes used on floors shall provide a slip-resistant finish. (III)

65.23(2) Equipment. Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

a. All facilities shall be provided with clean and sanitary storage for cleaning equipment, supplies, and utensils. In facilities over 15 beds, a janitor's closet shall be provided. It shall be equipped with water for filling scrub pails and a janitor's sink for emptying scrub pails. A hallway or corridor shall not be used for storage of equipment. (III)

b. Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

c. All containers for trash shall be watertight, rodent-proof, and have tight-fitting covers and shall be thoroughly cleaned each time a container is emptied. (III)

d. All wastes shall be properly disposed of in compliance with the local ordinances and state codes. (III)

65.23(3) Bedrooms. Each resident shall be provided with a bed, substantially constructed and in good repair. (III)

a. Rollaway beds, metal cots, or folding beds are not acceptable. (III)

b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately 5 inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size. (III)

c. There shall be a comfortable chair, either a rocking chair or arm chair, per resident bed. The resident's personal wishes shall be considered and documented. (III)

d. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

e. There shall be a bedside table with a drawer and a reading lamp for each resident. (III)

f. All furnishings and equipment shall be durable, cleanable, and appropriate to its function. (III)

g. All resident areas shall be decorated, painted, and furnished to provide a homelike atmosphere and in a manner which is age and culture appropriate. (III)

h. Upholstery materials shall be moisture- and soil-resistant, except on furniture which is provided and owned by the resident. (III)

i. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

j. Beds shall not be placed with the side of the bed against a radiator or in close proximity to it unless the radiator is covered to protect the resident from contact with it or from excessive heat. (III)

65.23(4) Bath and toilet facilities. All lavatories shall have nonreusable towels or an air dryer and an available supply of soap. (III)

65.23(5) Dining and living rooms. Dining rooms and living rooms shall be available for use by residents at appropriate times to allow social, diversional, individual, and group activities. (III)

a. Every facility shall have a dining room and a living room easily accessible to all residents which are never used as bedrooms. (III)

b. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 481—subrule 61.6(2) are met. (III)

c. Living rooms shall be suitably furnished and maintained for the use of residents and their visitors and may be used for recreational activities. (III)

d. Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

65.23(6) Family and employee accommodations. Resident bedrooms shall not be occupied by employees, family members of employees, or family members of the licensee. (III)

a. In facilities where the total occupancy of family, employees, and residents is five or fewer, one toilet and one tub or shower is the minimum requirement. (III)

b. In all health care facilities, if the family or employees live within the facility, living quarters shall be required for the family or employees separate from areas provided for residents. (III)

65.23(7) Pets—policies. Any facility in which a pet is living shall implement written policies and procedures addressing the following:

a. Vaccination schedule; (III)

b. Veterinary visit schedule; (III)

c. Housing or sleeping quarters; (III) and

d. Assignment of responsibility for feeding, bathing and cleanup. (III)

65.23(8) Maintenance. Each facility shall establish a program to ensure continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout. In

facilities over 15 beds, this program shall be in writing and be available for review by the department. (III)

a. The buildings, furnishings and grounds shall be maintained in a clean, orderly condition and be in good repair. (III)

b. The buildings and grounds shall be kept free of flies, other insects, rodents, and their breeding areas. (III)

65.23(9) *Buildings, furnishings, and equipment.*

a. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per employee on duty from 6 p.m. to 6 a.m. (III)

b. All windows shall be supplied with curtains and shades or drapes which are kept in good repair. (III)

c. Wherever glass sliding doors or transparent panels are used, they shall be marked conspicuously and decoratively. (III)

65.23(10) *Water supply.* Every facility shall have an adequate water supply from an approved source. A municipal source of water shall be considered as meeting this requirement. Private sources of water to a facility shall be tested annually and the report submitted with the annual application for license. (III)

a. A bacterially unsafe source of water shall be grounds for denial, suspension, or revocation of license. (III)

b. The department may require testing of private sources of water to a facility at its discretion in addition to the annual test. The facility shall supply reports of tests as directed by the department. (III)

This rule is intended to implement Iowa Code section 135C.14.

481—65.24(135C) Care review committee. Each facility shall have a care review committee in accordance with Iowa Code section 135C.25, which shall operate within the scope of the rules for care review committees promulgated by the department on aging. (III)

65.24(1) *Role of committee in complaint investigations.*

a. The department shall notify the facility's care review committee of a complaint from the public. The department shall not disclose the name of a complainant.

b. The department may refer complaints to the care review committee for initial evaluation or investigation by the committee pursuant to rules promulgated by the department on aging. Within ten days of completion of the investigation, the committee shall report to the department in writing the results of the evaluation of the investigation.

c. When the department investigates a complaint, upon conclusion of its investigation, it shall notify the care review committee and the department on aging of its findings, including any citations and fines issued.

d. Results of all complaint investigations addressed by the care review committee shall be forwarded to the department within ten days of completion of the investigation.

65.24(2) *Complaints monitored.* The care review committee shall, upon department request, be responsible for monitoring correction of substantiated complaints.

65.24(3) *Family member information.* When requested, names, addresses and telephone numbers of family members shall be given to the care review committee, unless the family refuses. The facility shall provide a form on which a family member may refuse to have the member's name, address or telephone number given to the care review committee.

This rule is intended to implement Iowa Code section 135C.25.

481—65.25(135C) Residents' rights in general. Each facility shall ensure that policies and procedures are written and implemented which include at least provisions in subrules 65.25(1) to 65.25(21). These shall govern all services provided to staff, residents, their families or legal representatives. The policies and procedures shall be available to the public and shall be reviewed annually. (II)

65.25(1) *Grievances.* Written policies and procedures shall include a method for submitting grievances and recommendations by residents or their legal representatives and for ensuring a response

and disposition by the facility. The written procedure shall ensure protection of the resident from any form of reprisal or intimidation and shall include:

a. An employee or an alternate designated to be responsible for handling grievances and recommendations; (II)

b. Methods to investigate and assess the validity of a grievance or recommendation; (II) and

c. Methods to resolve grievances and take action. (II)

65.25(2) *Informed of rights.* Policies and procedures shall include a provision that residents be fully informed of their rights and responsibilities as residents and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or when the facility adopts or amends residents' rights policies. It shall be posted in locations accessible to all residents. (II)

a. The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from residents. The facility shall communicate these expectations during a period not more than two weeks before or later than five days after admission. The communication shall be in writing in a separate handout or brochure describing the facility. It shall be interpreted verbally, as part of a preadmission interview, resident counseling, or in individual or group orientation sessions after admission. (II)

b. Residents' rights and responsibilities shall be presented in language understandable to residents. If the facility serves residents who do not speak English or are deaf, steps shall be taken to translate the information into a foreign or sign language. Blind residents shall be provided either Braille or a recording. Residents shall be encouraged to ask questions about their rights and responsibilities. Their questions shall be answered. (II)

c. A statement shall be signed by the resident and legal guardian, if applicable, to indicate the resident understands these rights and responsibilities. The statement shall be maintained in the record. The statement shall be signed no later than five days after admission. A copy of the signed statement shall be given to the resident or legal guardian. (II)

d. All residents, next of kin, or legal guardian shall be advised within 30 days of changes made in the statement of residents' rights and responsibilities. Appropriate means shall be used to inform non-English-speaking, deaf or blind residents of changes. (II)

65.25(3) *Resident abuse prohibited.* Each resident shall receive kind and considerate care at all times and shall be free from physical, sexual, mental and verbal abuse, exploitation, and physical injury. (I, II)

65.25(4) *Claim of abuse.* Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain the separation until the abuse investigation is completed. (I, II)

65.25(5) *Report of abuse.* Pursuant to Iowa Code chapter 235B, a mandatory reporter of dependent adult abuse is any person who, in the course of employment, examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse. This includes a member of the staff or employee of a health care facility. (II, III)

If a staff member or employee is required to report pursuant to this subrule, the staff member or employee shall immediately notify the person in charge of the facility or the person's designated agent, and the person in charge or the designated agent shall make the report to the department of human services. (II, III)

65.25(6) *Informed of health condition.* Each resident or legal guardian shall be fully informed by a physician of the health and medical condition of the resident unless a physician documents reasons not to in the resident's record. (II)

65.25(7) *Research.* The resident or legal guardian shall decide whether a resident participates in experimental research. Participation shall occur only when the resident or guardian is fully informed and signs a consent form. (II, III)

Any clinical investigation involving residents must be sponsored by an institution with a human subjects review board functioning in accordance with the requirement of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended December 1, 1981 (45 CFR 46). (III)

65.25(8) Resident work. Services performed by the resident for the facility shall be in accordance with the IPP. (II)

a. Residents shall not be used to provide a source of labor for the facility against the resident's will. Physician's approval is required for all work programs and must be renewed yearly. (II, III)

b. If the individual program plan requires activities for therapeutic or training reasons, the plan for these activities must be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time limited and reviewed at least quarterly. (II, III)

c. A resident engaged in work programs in the ICF/PMI shall be paid wages commensurate with wage and hour regulations for comparable work and productivity. (II)

d. The resident shall have the right to employment options commensurate with training and skills. (II)

e. Residents performing work shall not be used to replace paid employees to fulfill staff requirements. (II)

65.25(9) Encouragement to exercise rights. Residents shall be encouraged and assisted throughout their period of stay to exercise resident and citizen rights. Residents may voice grievances and recommend changes in policies and services to administrative staff or to an outside representative of their choice free from interference, coercion, discrimination, or reprisal. (II)

65.25(10) Posting names. The facility shall post the name, telephone number, and address of the:

a. Long-term care resident's advocate/ombudsman; (II)

b. Survey agency; (II)

c. Local law enforcement agency; (II)

d. Care review committee members; (II)

e. Administrator; (II)

f. Members of the board of directors; (II)

g. Corporate headquarters; (II) and the

h. Iowa Protection and Advocacy Services, Inc. (II)

The text of Iowa Code section 135C.46 shall also be available to provide residents another course of redress. These items shall be posted in an area where residents and visitors can read them. (II)

65.25(11) Dignity preserved. Residents shall be treated with consideration, respect, and full recognition of their dignity and individuality, including privacy in treatment and in care of personal needs. (II)

a. Staff shall display respect for residents when speaking with, caring for, or talking about them as constant affirmation of the individuality and dignity of human beings. (II)

b. Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping, eating, and times to retire at night and arise in the morning shall be elicited and considered by the facility. The facility shall make every effort to match nonsmokers with other nonsmokers. (II)

c. Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules; however, residents shall be encouraged to participate in recreational programs. (II)

d. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door shall shield the resident from passersby. People not involved in the care of a resident shall not be present without the resident's consent during examination or treatment. (II)

e. Privacy for each person shall be maintained when residents are being taken to the toilet or being bathed and while they are being helped with other types of personal hygiene, except as needed for resident safety or assistance. (II)

f. Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of response. This does not apply under emergency conditions. (II)

65.25(12) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents. Each resident may send and receive personal mail unopened unless prohibited in the IPP which has explicit approval of the resident or legal guardian. Telephones consistent with ANSI standards 42 CFR 405.1134(c) (10-1-86) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

65.25(13) Visiting policies and procedures. Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

a. Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- (1) The resident refuses to see the visitor(s). (II)
- (2) The visit would not be in accordance with the IPP. (II)
- (3) The visitor's behavior is unreasonably disruptive to the functioning of the facility. (II)

Reasons for denial of visitation shall be documented in resident records. (II)

b. Decisions to restrict a visitor shall be reevaluated at least quarterly by the QMHP or at the resident's request. (II)

c. Space shall be provided for residents to receive visitors in comfort and privacy. (II)

65.25(14) Resident activities. Each resident may participate in activities of social, religious, and community groups as desired unless contraindicated for reasons documented by the attending physician or qualified mental health professional, as appropriate, in the resident's record. (II)

Residents who wish to meet with or participate in activities of social, religious or community groups in or outside the facility shall be informed, encouraged, and assisted to do so. (II)

Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, QMHP, or facility administrator for refusing permission. (II)

65.25(15) Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided use is not otherwise prohibited in these rules. (II)

a. Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a secure location which is convenient to the resident. (II)

b. Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

c. Any personal clothing or possession retained by the facility for the resident shall be identified and recorded on admission and the record placed on the resident's chart. The facility shall be responsible for secure storage of items. They shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

65.25(16) Sharing rooms. Residents, including spouses staying in the same facility, shall be permitted to share a room, if available, if requested by both parties, unless reasons to the contrary are in the IPP. Reasons for denial shall be documented in the resident's record. (II)

65.25(17) Choice of physician and pharmacy. Each resident shall be permitted free choice of a physician and a pharmacy. The facility may require the pharmacy selected to use a drug distribution system compatible with the system currently used by the facility. (II)

481—65.26(135C) Incompetent residents. Each facility shall provide that all rights and responsibilities of incompetent residents devolve to the legal guardian when a hearing has been held and the resident is judged incompetent in accordance with state law. (II)

A facility is not absolved from advising incompetent residents of their rights to the extent the resident is able to understand them. The facility shall also advise the legal guardian, if any, and acquire a statement indicating an understanding of resident's rights. (II)

This rule is intended to implement Iowa Code sections 135C.14(8) and 135C.24.

481—65.27(135C) County care facilities. In addition to these rules, county care facilities licensed as intermediate care facilities for persons with mental illness must also comply with department of human services rules 441—Chapter 37. Violation of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

This rule is intended to implement Iowa Code section 227.4.

481—65.28(135C) Violations. Classification of violations is I, II and III, determined by the division using the provisions in 481—Chapter 56, “Fining and Citations,” to enforce a fine to cite a facility.

481—65.29(135C) Another business or activity in a facility. A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs “a” through “j” of this rule. (I, II, III)

65.29(1) The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a. Health and safety risks for residents;
- b. Compatibility of the proposed business or activity with the facility program;
- c. Noise created by the proposed business or activity;
- d. Odors created by the proposed business or activity;
- e. Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- f. Use of the facility's corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- g. Proposed staffing for the business or activity;
- h. Sharing of services and staff between the proposed business or activity and the facility;
- i. Facility layout and design; and
- j. Parking area utilized by the business or activity.

65.29(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

65.29(3) A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules and 481—Chapter 61. (I, II, III)

481—65.30(135C) Respite care services. Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A facility which chooses to provide respite care services must meet the following requirements related to respite care services and must be licensed as a health care facility.

65.30(1) A facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

65.30(2) Rules regarding involuntary discharge or transfer rights do not apply to residents who are being cared for under a respite care contract.

65.30(3) The facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements for contracts between a health care facility and resident, except the requirements concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons.

65.30(4) Respite care services shall not be provided by a facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 135C.2(6), 135C.4, 135C.6(2), 135C.6(3), 135C.7, 135C.8, 135C.14, 135C.16(2), 135C.23, 135C.24, 135C.25, 135C.31, and 227.4.

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CHAPTER 4
EMPLOYERS

[Prior to 6/9/04, see 581—Ch 21]

495—4.1(97B) Covered employers.

4.1(1) Definition. All public employers in the state of Iowa, its cities, counties, townships, agencies, political subdivisions, instrumentalities and public schools are required to participate in IPERS. For the purposes of these rules, the following definitions also apply:

a. "Political subdivision" means a geographic area or territorial division of the state which has responsibility for certain governmental functions. Political subdivisions are characterized by public election of officers and taxing powers. The following examples are representative: cities, municipalities, counties, townships, schools and school districts, drainage and levee districts, and utilities.

b. "Instrumentality of the state or a political subdivision" means an independent entity that is organized to carry on some specific function of government. Public instrumentalities are created by some form of governmental body, including federal and state statutes and regulations, and are characterized by being under the control of a governmental body. Such control may include final budgetary authorization, general policy development, appointment of a board by a governmental body, and allocation of funds.

c. "Public agency" means state agencies and agencies of political subdivisions. Representative examples include an executive board, commission, bureau, division, office, or department of the state or a political subdivision.

d. Effective July 1, 1994, the definition of employer includes an area agency on aging that does not offer an alternative plan to all of its employees that is qualified under the federal Internal Revenue Code.

Covered employers include, but are not limited to: the state of Iowa and its administrative agencies; counties, including their hospitals and county homes; cities, including their hospitals, park boards and commissions; recreation commissions; townships; public libraries; cemetery associations; municipal utilities including waterworks, gasworks, electric light and power; school districts including their lunch and activity programs; state colleges and universities; and state hospitals and institutions.

An entity not already reporting to IPERS which meets the conditions for becoming an IPERS covered employer shall immediately contact IPERS to provide notice which includes the name and address of the entity and other information required by IPERS. If, after review of this information, IPERS determines that the entity should be enrolled as a covered employer, IPERS will notify the entity and provide an IPERS account number for the entity to use when submitting information. IPERS shall not be required to provide benefits otherwise available under Iowa Code chapter 97B for periods of service prior to the effective date for which IPERS actually approves the entity for coverage, unless the employer agrees to pay the full actuarial cost of providing such benefits.

An employer may request a revised beginning date for its status as a covered employer. The employer must submit acceptable proof to IPERS that its status as a covered employer began earlier than the date previously provided. In such case, the employer shall provide IPERS coverage retroactively to all employees providing services to that employer on or after the revised beginning date and shall pay all actuarial costs.

4.1(2) Name change. Any employer which has a change of name, address, title of the employer, its reporting official or any other identifying information shall immediately give notice in writing to IPERS. The notice shall provide IPERS with the following information:

- a.* Former name;
- b.* Former address;
- c.* IPERS account number;
- d.* New name, address, and telephone number of the employer;
- e.* Reason for the change if other than a change of reporting official; and
- f.* Effective date of the change.

4.1(3) Termination. Any employer which terminates or is dissolved for any reason shall provide IPERS with the following:

- a. Complete name and address of the dissolved entity;
- b. Assigned IPERS account number;
- c. Last date on which wages were paid;
- d. Date on which the entity dissolved;
- e. Reason for the dissolution;
- f. Whether or not the entity expects to pay wages in the future;
- g. Whether the entity is being absorbed by another covered employer;
- h. Name and address of absorbing employer if applicable; and
- i. Name and address of employer that will retain the records of the dissolved entity.

4.1(4) Reports of dissolved or absorbed employers. An employer that has been dissolved or entirely absorbed by another employer is required to file a monthly report with IPERS through the effective date on which it was dissolved or absorbed. Any wages paid after this date are reported under the account number assigned to the new or successor employer, if any.

4.1(5) IPERS account number. Each employer is assigned an IPERS account number. This number should be used on all correspondence and reporting forms directed to IPERS.

4.1(6) For patient advocates employed under Iowa Code section 229.19, the county or counties for which services are performed shall be treated as the covered employer(s) of such individuals, and each such employer is responsible for forwarding reports and for withholding and forwarding the applicable IPERS contributions on wages paid by each employer.

495—4.2(97B) Records to be kept by the employer.

4.2(1) General. Each employer shall maintain records to show the information hereinafter indicated. Records shall be kept in the form and manner prescribed by IPERS. Records shall be open to inspection and may be copied by IPERS and its authorized representatives at any reasonable time.

4.2(2) Records shall show with respect to each employee:

- a. Employee's name, address, gender, and social security account number, and other demographic information that may be required;
- b. Each date the employee was paid wages or other wage equivalent (e.g., room, board);
- c. Total amount of wages paid on each date including noncash wage equivalents;
- d. Total amount of wages including wage equivalents on which IPERS contributions are payable;
- e. Amount withheld from wages or wage equivalents for the employee's share of IPERS contributions; and
- f. Effective January 1, 1995, records will show, with respect to each employee, member contributions picked up by the employer.

4.2(3) Reports.

a. Each employer shall make reports as IPERS may require and shall comply with the instructions provided by IPERS for the reports.

b. Effective July 1, 1991, employers must report all terminating employees to IPERS within seven working days following the employee's termination date. This report shall contain the employee's last-known mailing address and such other information as IPERS might require.

c. Effective December 31, 2004, and annually thereafter, employers whose job classes include correctional officers, correctional supervisors, and others whose primary purpose is, through ongoing direct inmate contact, to enforce and maintain discipline, safety and security within a correctional facility shall submit to IPERS each calendar year a list of jobs that qualify for protection occupation class coverage. This report shall also contain any changes in the designation of jobs as qualifying or not qualifying for protection occupation class coverage and effective dates of changes. IPERS' sole responsibility with respect to protection occupation status determinations is to ascertain whether IPERS' records correctly reflect service credit and contributions that are in accordance with the employer's designation of a position as being within a protection occupation class.

4.2(4) Fees. IPERS may assess to the employer a fee for administrative costs as described in subrule 4.3(6).

[ARC 8601B, IAB 3/10/10, effective 4/14/10]

495—4.3(97B) Wage reporting and payment of contributions by employers.

4.3(1) *Payment of contributions.* For wages paid on or after July 1, 2008, all covered employers are required to pay contributions on a monthly basis. Upon enrollment as an IPERS covered employer, the employer shall receive the appropriate forms and instructions from IPERS to submit contributions. IPERS will provide monthly statements to each employer.

IPERS accepts the payment of contributions through electronic funds transfer. Payments utilizing the electronic funds transfer system shall be made according to the procedure described in subrule 4.3(3).

IPERS accepts the payment of contributions using checks and remittance advice forms. Employers filing monthly employer remittance advice forms on paper for two or more employers shall attach the checks to each remittance form. Checks shall be made payable to the Iowa Public Employees' Retirement System and mailed with the employer remittance advice form to IPERS, P.O. Box 9117, Des Moines, Iowa 50306-9117. Effective August 1, 2008, such payments and reports shall be subject to a fee as described in subrule 4.3(6).

4.3(2) *Wage reports.* For wages paid on or after July 1, 2008, all IPERS covered employers are required to file wage reports on a monthly basis. IPERS will provide the forms and instructions for wage reporting to employers. Each wage report must include the required information for all employees who earned reportable wages or wage equivalents under IPERS. The reports must be received by IPERS on or before the fifteenth day of the month following the month in which the wages were paid. If the fifteenth day falls on a weekend or holiday, the wage report is due on the next regularly scheduled business day.

Effective August 1, 2008, IPERS shall accept wage reports electronically via the IPERS' employer self service Web application, on compact discs, or as a paper report. However, for those employers submitting reports on compact discs or on paper, IPERS shall charge a fee as described in subrule 4.3(6).

4.3(3) *Deadlines for payment of contributions.*

a. Contributions must be paid monthly and must be received by IPERS on or before the fifteenth day of the month following the month in which wages were paid. If the fifteenth day falls on a weekend or holiday, the contribution is due on the next regularly scheduled business day.

b. For employers paying contributions by electronic funds transfer, wage reports and contributions may be submitted at the same time.

4.3(4) *Request for time extension.* A request for an extension of time to file a wage report or pay a contribution may be granted by IPERS for good cause if a request is made before the due date, but no extension shall exceed 15 days beyond the due date. If an employer that has been granted an extension fails to submit the wage report or pay the contribution on or before the end of the extension period, the applicable interest and fees shall be charged and paid from the original due date as if no extension had been granted. If the fifteenth day falls on a weekend or holiday, the contribution or report is due on the next regularly scheduled business day.

To establish good cause for an extension of time to file a wage report or pay contributions, the employer must show that the delinquency was not due to mere negligence, carelessness or inattention. The employer must affirmatively show that it did not file the report or timely pay because of some occurrence beyond the control of the employer.

4.3(5) *No reportable wages.* When an employer has no reportable wages during the applicable reporting period, the wage reporting document shall be filed according to subrule 4.3(2). Even if there are no reportable wages, the employer's account is considered delinquent for the reporting period and is subject to a fee until the report is filed. However, if the employer has notified IPERS on or before the due date that there are no wages to report, IPERS will adjust the due date, and no fee will be charged.

4.3(6) *Fees for noncompliance.* IPERS is authorized to impose reasonable fees on employers that do not file wage reports through the IPERS' employer self service Web application as described in subrule 4.3(2), that fail to timely file accurate wage reports, or that fail to pay contributions when due pursuant to subrule 4.3(3).

For submissions filed on or after August 1, 2008, IPERS shall charge employers a processing fee of \$20 plus 25 cents per employee for late submissions and manual processing of wage reports by IPERS. Employers that are late or that do not use IPERS' employer self service Web application may be charged both fees. In addition, if a fee for noncompliance is not paid by the fifteenth day of the month after the fee

is assessed, the fee will accrue interest daily at the interest rate provided in Iowa Code section 97B.70. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full.

If the due date for a fee falls on a weekend or holiday, the due date shall be the next regularly scheduled business day.

4.3(7) *Erroneously reported wages for employees not covered under IPERS.* Employers that erroneously report wages for employees who are not eligible for coverage under IPERS may file an IPERS wage reporting adjustment form. IPERS shall return a warrant or issue a credit for both the employer and employee contributions made in error. The employer is responsible for returning the employees' share and for filing corrected federal and state wage reporting forms. Adjustments in such cases will be reported on the employer's monthly statement. Under no circumstance shall the employer adjust these wages by underreporting wages on a future periodic wage reporting document. Wages shall never be reported as a negative amount. An employer that completes the employer portion of an employee's request for a refund on an IPERS refund application form will not be permitted to file a periodic wage reporting adjustment form for that employee for the same time period. No fee will be assessed to employers that correct information as provided under this subrule.

4.3(8) *Contributions paid on wages in excess of the annual covered wage maximum.* For wages paid on or after July 1, 2008, whenever IPERS determines that an employee's wages will exceed the annual maximum established under Section 401(a)(17)(A) and the cost-of-living adjustments to that maximum permitted under Section 401(a)(17)(B) of the Internal Revenue Code during a given month, IPERS shall notify the applicable employer and shall return the related excess contributions. IPERS will detail on the monthly report those employees for whom wages were reported in excess of the covered wage ceiling. The employer is responsible for returning the employee's share of excess contributions and making the applicable tax corrections.

4.3(9) *Termination within less than six months of the date of employment.* If an employee hired for permanent employment terminates within six months of the date of employment, the employer may file an IPERS form for reporting adjustments to receive a warrant or a credit, as elected by the employer, for both the employer's and employee's portions of the contributions. It is the responsibility of the employer to return the employee's share. "Termination within less than six months of the date of employment" means employment is terminated prior to the day before the employee's six-month anniversary date. For example, an employee hired on February 10 whose last day is August 8 would be treated as having resigned within less than six months. An employee hired on February 10 whose last day is August 9 (the day before the six-month anniversary date, August 10) would be treated as having worked six months and would be eligible for a refund.

4.3(10) *Reinstatement following an employment dispute.* Employees who are reinstated following an employment dispute may restore membership service credit as described in 495—9.5(97B).

[ARC 9397B, IAB 2/23/11, effective 3/30/11]

495—4.4(97B) *Accrual of interest and application of employer payments.* Interest or charges as provided under Iowa Code section 97B.9 shall accrue on all employer payments not received by IPERS by the due date, except that interest or charges may be waived by IPERS if the employer requests an extension of time under subrule 4.3(4) prior to the due date. Effective August 1, 2008, employers that remit late contributions shall be charged a minimum of \$20 or interest at the rate provided in Iowa Code section 97B.70, whichever is greater. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full. Payments received from employers having unpaid account balances shall first be applied to the oldest outstanding balance.

495—4.5(97B) *Credit memos voided.* Rescinded IAB 3/26/08, effective 4/30/08.

495—4.6(97B) *Contribution rates.* The following contribution rate schedule, payable on the covered wage of the member, is determined by the position or classification and the occupation class code of the member.

4.6(1) Contribution rates for regular class members.

a. The following contribution rates were established by the Iowa legislature for all regular class members for the indicated periods:

	Effective July 1, 2007	Effective July 1, 2008	Effective July 1, 2009	Effective July 1, 2010	Effective July 1, 2011
Combined rate	9.95%	10.45%	10.95%	11.45%	13.45%
Employer	6.05%	6.35%	6.65%	6.95%	8.07%
Employee	3.90%	4.10%	4.30%	4.50%	5.38%

b. Effective July 1, 2012, and every year thereafter, the contribution rates for regular members shall be publicly declared by IPERS staff no later than the preceding December as determined by the annual valuation of the preceding fiscal year. The public declaration of contribution rates will be followed by rule making that will include a notice and comment period and that will become effective July 1 of the next fiscal year. Contribution rates for regular members are as follows.

	Effective July 1, 2012	Effective July 1, 2013
Combined rate	14.45%	14.88%
Employer	8.67%	8.93%
Employee	5.78%	5.95%

4.6(2) Contribution rates for sheriffs and deputy sheriffs are as follows.

	Effective July 1, 2009	Effective July 1, 2010	Effective July 1, 2011	Effective July 1, 2012	Effective July 1, 2013
Combined rate	15.24%	17.88%	19.66%	19.80%	19.76%
Employer	7.62%	8.94%	9.83%	9.90%	9.88%
Employee	7.62%	8.94%	9.83%	9.90%	9.88%

4.6(3) Contribution rates for protection occupations are as follows.

	Effective July 1, 2009	Effective July 1, 2010	Effective July 1, 2011	Effective July 1, 2012	Effective July 1, 2013
Combined rate	15.34%	16.59%	16.62%	17.11%	16.90%
Employer	9.20%	9.95%	9.97%	10.27%	10.14%
Employee	6.14%	6.64%	6.65%	6.84%	6.76%

4.6(4) Members employed in a “protection occupation” shall include:

a. Conservation peace officers. Effective July 1, 2002, all conservation peace officers, state and county, as described in Iowa Code sections 350.5 and 456A.13.

b. Effective July 1, 1994, a marshal in a city not covered under Iowa Code chapter 400 or a firefighter or police officer of a city not participating under Iowa Code chapter 410 or 411. (See employee classifications in rule 495—5.1(97B).) Effective January 1, 1995, part-time police officers shall be included.

c. Correctional officers as provided for in Iowa Code section 97B.49B. Employees who, prior to December 22, 1989, were in a “correctional officer” position but whose position is found to no longer meet this definition on or after that date shall retain coverage, but only for as long as the employee is in that position or another “correctional officer” position that meets this definition. Movement to a position that does not meet this definition shall cancel “protection occupation” coverage.

d. Airport firefighters employed by the military division of the department of public defense (airport firefighters). Effective July 1, 2004, airport firefighters become part of and shall make the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1,

1994, through June 30, 2004, airport firefighters were grouped with and made the same contributions as sheriffs and deputy sheriffs. From July 1, 1988, through June 30, 1994, airport firefighters were grouped with and made the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1986, through June 30, 1988, airport firefighters were a separate protection occupation group and made contributions at a rate calculated for members of that group. Prior to July 1, 1986, airport firefighters were grouped with regular members and made the same contributions as regular members.

Notwithstanding the foregoing, all airport firefighter service prior to July 1, 2004, shall be coded by IPERS as sheriff/deputy sheriff/airport firefighter service, and all airport firefighter service after June 30, 2004, shall be coded by IPERS as protection occupation service. This coding, however, shall not supersede provisions of this title that require members to make contributions at higher rates in order to receive certain benefits, such as in the hybrid formula pursuant to 495—12.4(97B).

e. Airport safety officers employed under Iowa Code chapter 400 by an airport commission in a city with a population of 100,000 or more, and employees covered by the Iowa Code chapter 8A merit system whose primary duties are providing airport security and who carry or are licensed to carry firearms while performing those duties.

f. Effective July 1, 1990, an employee of the state department of transportation who is designated as a “peace officer” by resolution under Iowa Code section 321.477.

g. Effective July 1, 1992, a fire prevention inspector peace officer employed by the department of public safety. Effective July 1, 1994, a fire prevention inspector peace officer employed before that date who does not elect coverage under Iowa Code chapter 97A in lieu of IPERS.

h. Effective July 1, 1994, through June 30, 1998, a parole officer III with a judicial district department of correctional services.

i. Effective July 1, 1994, through June 30, 1998, a probation officer III with a judicial district department of correctional services.

j. Effective July 1, 2008, county jailers and detention officers working as jailers.

k. Effective July 1, 2008, National Guard installation security officers.

l. Effective July 1, 2008, emergency medical care providers.

m. Effective July 1, 2008, special investigators who are employed by county attorneys.

4.6(5) Service reclassification.

a. Prior to July 1, 2006, except as otherwise indicated in the implementing legislation or these rules, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall be coded by IPERS staff as special service if certified by the employer as constituting special service under current law. No additional contributions shall be required by regular service reclassified as special service under this paragraph.

b. Effective July 1, 2006, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall continue to be coded by IPERS staff as regular service unless the legislature specifically provides in its legislation for payment of the related actuarial costs of such reclassified service as required under Iowa Code section 97B.65.

4.6(6) Effective July 1, 2006, in the determination of a sheriff’s or deputy sheriff’s eligibility for benefits and the amount of such benefits under Iowa Code section 97B.49C, all protection occupation service credits for that member shall count toward the total years of eligible service as a sheriff or deputy sheriff. However, this subrule shall not be construed to alter the statutory requirement that a sheriff or deputy sheriff must be employed as a sheriff or deputy sheriff at termination of covered employment in order to qualify for benefits under Iowa Code section 97B.49C.

4.6(7) Pretax.

a. Effective January 1, 1995, employers must pay member contributions on a pretax basis for federal income tax purposes only. Such contributions are considered employer contributions for federal income tax purposes and employee contributions for all other purposes. Employers must reduce the member’s salary reportable for federal income tax purposes by the amount of the member’s contribution.

b. Salaries reportable for purposes other than federal income tax will not be reduced, including for IPERS, FICA, and, through December 31, 1998, state income tax purposes.

c. Effective January 1, 1999, employers must pay member contributions on a pretax basis for both federal and state income tax purposes.

[ARC 7591B, IAB 2/25/09, effective 7/1/09; ARC 7759B, IAB 5/6/09, effective 4/17/09; ARC 7916B, IAB 7/1/09, effective 8/5/09; ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 9397B, IAB 2/23/11, effective 3/30/11; ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 0662C, IAB 4/3/13, effective 5/8/13]

495—4.7(97B) Employee information to be provided by covered employers. Covered employers are required to enroll new employees prior to reporting wages for the new employees. Enrollment information shall include, but is not limited to, the following: member's name, social security number, date of birth, date of hire, occupation code, gender, mailing address, termination date and last check date, when appropriate, and employer identification number.

For new employee enrollments submitted on or after August 1, 2008, employers shall submit the required information using IPERS' employer self service Web application, on compact discs, or on paper. However, those employers submitting information on compact discs or on paper will be charged a fee as described in subrule 4.3(6).

495—4.8(97B) Additional employer contributions from employer-mandated reduction in hours or by the exercise of bumping rights to avoid a layoff. Effective January 1, 2009, this rule applies to the restoration of covered wages reduced by an employer-mandated reduction in hours (EMRH) or the restoration of covered wages reduced by the exercise of bumping rights to avoid a layoff. It does not apply to reductions in base wages, reduced overtime wages, permanent layoffs or other termination of employment situations. EMRH references in this rule shall apply both to situations involving the loss of covered wages due to employer-mandated reductions in hours and to the loss of covered wages due to the exercise of bumping rights to avoid a layoff.

4.8(1) A member may restore the member's three-year average covered wage to the amount that it would have been but for an EMRH by completing the IPERS EMRH application form and related payroll deduction authorization and by filing the application and payroll deduction authorization forms with the employer. By so doing, the member agrees to pay the employee and employer contributions for all reduced work hours and bumping reductions between January 1, 2009, through June 30, 2011.

4.8(2) A member cannot pay the EMRH contributions described under this rule in any manner except through payroll deductions.

4.8(3) The payroll deduction authorization described under this rule shall be irrevocable, except upon death, retirement or termination of employment. If revoked by the member's death, retirement, or termination of employment, all amounts held by an employer in the member's name shall be forwarded to the member along with the member's final wages.

4.8(4) A member may obtain a refund of EMRH contributions collected under this rule as part of a refund of the member's entire account balance or an actuarial equivalent (AE) payment, but a member who commences a monthly retirement allowance shall not receive a refund of any amounts contributed, even if the covered wages being restored are not used in the member's three-year average covered wage.

4.8(5) A covered employer must cooperate with an eligible member's request for payroll deductions using the applicable IPERS forms. Employers shall be required to complete and submit wage certifications showing the covered wages that would have been reported but for the EMRH.

4.8(6) After IPERS has received and processed wage certification forms, the employer will be billed for the applicable EMRH contributions on the next employer monthly statement. If contributions are not paid by the employer statement's due date, the employer will be assessed late fees and interest in accordance with rule 495—4.3(97B).

4.8(7) In completing the federal and state wage reporting forms to be filed with the federal and state tax authorities, an employer shall treat the EMRH contributions collected and forwarded to IPERS the same as pretax IPERS employee contributions.

4.8(8) Upon receipt of the contributions pursuant to this rule, IPERS shall apply them to the member's account as pretax employee contributions.

4.8(9) This rule applies to reductions in wages caused by an EMRH through June 30, 2011. An employer's collection of contributions from such wages shall terminate as of midnight, July 31, 2011. All completed EMRH forms and contributions collected under this rule must be forwarded to IPERS by a covered employer no later than August 15, 2011.

[ARC 7759B, IAB 5/6/09, effective 4/17/09; ARC 7916B, IAB 7/1/09, effective 8/5/09; ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10]

These rules are intended to implement Iowa Code sections 97B.4, 97B.9, 97B.14, 97B.14A, 97B.38, 97B.49A to 97B.49I, 97B.65 and 97B.70 and 2009 Iowa Acts, chapter 170, section 51, as amended by 2010 Iowa Acts, House File 2518, sections 36 and 41.

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CHAPTER 5
EMPLOYEES

[Prior to 6/9/04, see 581—Ch 21]

495—5.1(97B) Identification of employees covered by the IPERS retirement law.

5.1(1) *Definition of employee—generally.* A person is in employment as defined by Iowa Code chapter 97B if the person and the covered employer enter into a relationship which both recognize to be that of employer/employee. An employee is an individual who is subject to control by the agency for whom the individual performs services for wages. The term “control” refers only to employment and includes control over the way the employee works, where the employee works and the hours the employee works. The control need not be actually exercised for an employer/employee relationship to exist; the right to exercise control is sufficient. A public official may be an “employee” as defined in the agreement between the state of Iowa and the Secretary of Health and Human Services, without the element of direction and control.

A person is not in employment if the person volunteers services to a covered employer for which the person receives no remuneration.

5.1(2) *Optional coverage procedures—July 1, 1994, through December 31, 1998.* Effective July 1, 1994, a person who is employed in a position which allows IPERS coverage to be elected as specified in Iowa Code section 97B.1A(8) must file a one-time election form with IPERS for coverage. If the person was employed before July 1, 1994, the election must be postmarked on or before July 1, 1995. If the person was employed on or after July 1, 1994, the election must be postmarked within 60 days from the date the person was employed. Coverage will be prospective from the date the election is approved by IPERS. The election, once filed, is irrevocable and continues until the member terminates covered employment. The election window does not allow members who had been in coverage to elect out.

5.1(3) *Election out of Iowa Code chapter 97B coverage by certain protection occupation groups.* Effective July 1, 1994, members employed before that date as a gaming enforcement officer, a fire prevention inspector peace officer, or an employee of the division of capitol police (except clerical workers), may elect coverage under Iowa Code chapter 97A in lieu of IPERS. The election must be directed to the board of trustees established in Iowa Code section 97A.5 and postmarked on or before July 1, 1995.

5.1(4) *Optional coverage procedures—January 1, 1999.* Effective January 1, 1999, new hires who may elect out of IPERS coverage shall be covered on the date of hire and shall have 60 days to elect out of coverage in writing using IPERS’ forms. Notwithstanding the foregoing, employees who had the right to elect IPERS coverage prior to January 1, 1999, but did not do so, shall be covered as of January 1, 1999, and shall have until December 31, 1999, to elect out of coverage.

495—5.2(97B) Coverage treatment for specific employee classifications. Employment as defined in Iowa Code chapter 97B is not synonymous with IPERS membership. Some classes of employees are explicitly excluded or membership is made optional under Iowa Code section 97B.1A(8) “b,” while other classes are excluded or membership is made optional by their nature. The following subrules are designed to clarify the status of certain employee positions.

5.2(1) Elected officials. Effective January 1, 1999, the following persons shall be covered by IPERS unless they elect out of coverage:

- a. Elected officials in positions for which the compensation is on a fee basis;
- b. Elected officials of school districts;
- c. Elected officials of townships; and
- d. Elected officials of other political subdivisions who are in part-time positions.

An elected official who becomes covered under this chapter may later terminate membership by informing IPERS in writing of the expiration of the member’s term of office or, if a member of the general assembly, of the intention to terminate coverage.

An elected official does not terminate covered employment with the end of each term of office if the official has been reelected for the same position. If elected for another position, the official shall be covered unless the official elects out of coverage.

5.2(2) County and municipal court bailiffs who receive compensation for duties shall be covered.

5.2(3) Full-time city attorneys shall be covered. Part-time city attorneys who are considered to be public officers or public employees shall be covered.

5.2(4) Magistrates shall be covered unless they elect out of IPERS coverage. Having made a choice to remain in IPERS coverage, a magistrate may not revoke that election and discontinue such coverage.

5.2(5) Office and clerical staff of a county medical examiner's office shall be covered. Effective January 1, 1995, county medical examiners and deputy county medical examiners who are full-time county employees shall be covered.

5.2(6) Police, firefighters, emergency personnel, and certain peace officers.

a. Effective July 1, 1994, police officers and firefighters of a city not participating in the retirement systems established under Iowa Code chapter 410 or 411 shall be covered.

b. Emergency personnel, such as ambulance drivers, who are deemed to be firefighters by the employer shall be covered as firefighters.

c. Effective January 1, 1995, part-time police officers shall be covered in the same manner as full-time police officers.

d. Reserve peace officers employed under Iowa Code chapter 80D shall not be covered in accordance with Iowa Code section 80D.14.

e. A police chief or fire chief who has submitted a written request to the board of trustees created by Iowa Code section 411.36 to be exempt from coverage under Iowa Code chapter 411 shall not be covered under IPERS in accordance with Iowa Code sections 384.6(1) and 411.3. The city shall make on behalf of such person the contributions required under Iowa Code section 384.6(1) to the International City Management Association/Retirement Corporation.

f. Peace officer candidates of the department of public safety shall not be covered.

5.2(7) County social welfare employees shall be covered.

5.2(8) Members of county soldiers relief commissions and their administrative or clerical employees shall be covered.

5.2(9) Part-time elected mayors, mayors of townships, and mayors who are paid on a fee basis are covered under IPERS unless they elect out of coverage. All other mayors, including appointed mayors and full-time elected mayors, whether elected by popular vote or by some other means, are covered.

5.2(10) Field assessors shall be covered.

5.2(11) Members of county boards of supervisors who receive an annual salary shall be covered. Effective for terms of office beginning January 1, 1999, part-time members of county boards of supervisors who receive an annual salary or are paid on a per diem basis shall be covered unless they elect out of coverage.

5.2(12) Temporary employees of the general assembly who are employed for less than six months in a calendar year or work less than 1,040 hours in a calendar year shall be covered unless the employee elects out of coverage. If coverage is elected, the member may not terminate coverage until termination of covered employment.

5.2(13) Effective July 1, 2008, temporary employees shall not be covered provided that they have not established an ongoing relationship with an IPERS covered employer. An ongoing relationship with an IPERS covered employer is established when:

a. The employee is paid covered wages of \$1,000 or more per quarter in two consecutive quarters; or

b. The employee is employed by a covered employer for 1,040 or more hours in a calendar year.

Coverage shall begin when the permanency of the relationship is established and shall continue until the employee's relationship with the covered employer is severed. If there is no formal severance, coverage for a person hired for temporary employment who has established an ongoing relationship with a covered employer shall continue until that person completes four consecutive calendar quarters in which no services are performed for that employer after the last covered calendar quarter.

No service credit will be granted to a temporary employee who has become a covered employee under this rule for any quarter in which no covered wages are reported unless the employee is on a leave of absence that qualifies for service credit under Iowa Code section 97B.1A(20). Contributions shall be paid, and service credit shall be accrued, when wages are paid in the quarter after the ongoing relationship has been established.

5.2(14) Drainage district employees who have vested rights to IPERS through earlier participation or employees of drainage districts shall be covered unless they elect out of coverage.

5.2(15) Full-time and part-time county attorneys shall be covered.

5.2(16) Tax study committee employees shall be covered.

5.2(17) School bus drivers who are considered to be public employees shall be covered. School bus drivers who are independent contractors shall not be covered. A determination must be made by IPERS on the facts presented on a case-by-case basis.

5.2(18) Persons who are enrolled as students and whose primary occupations are as students shall not be covered. Full-time or part-time students employed part-time by the educational institution where they are enrolled shall not be covered. All other students beyond high school are not exempt from IPERS coverage. Full-time and part-time student status is as defined by the individual educational institutions. Full-time and part-time employment status is as defined by the individual employers.

The paragraph above shall not be construed to require or permit IPERS coverage for high school students and students in the lower grades who are concurrently employed (including employment during breaks between quarters, semesters, or annual academic terms) by a covered employer.

5.2(19) Foreign exchange teachers and visitors including alien scholars, trainees, professors, teachers, research assistants and specialists in their fields of specialized knowledge or skill shall not be covered.

5.2(20) Members of any other retirement system in Iowa maintained in whole or in part by public funds shall not be covered. However, effective July 1, 1996, an employee who has two jobs, one covered by IPERS and one covered by another retirement system in Iowa, shall remain an IPERS covered employee, unless the employee receives credit in such other retirement system for both jobs.

5.2(21) Members who are contributing to the federal civil service retirement system or federal employees retirement system shall not be covered. However, effective July 1, 1996, an employee who has two jobs, one covered by IPERS and one covered by a federal retirement system, shall be considered as an IPERS covered employee, unless the employee receives credit in such federal retirement system for both jobs.

5.2(22) Employees of credit unions without capital stock organized and operated for mutual purposes without profit shall not be covered.

5.2(23) Members of the ministry, rabbinate or other religious order who perform full-time or part-time religious service for a covered employer shall be covered. However, members of the ministry, rabbinate or other religious order who have taken the vow of poverty may elect out of coverage.

5.2(24) Any physician, surgeon, dentist or member of other professional groups employed full-time by a covered employer shall be covered. However, any member of a professional group who performs part-time service for any public agency but whose private practice provides the major source of income shall not be covered, except for city attorneys and health officials.

5.2(25) Interns and resident doctors employed by a state or local hospital, school or institution shall not be covered.

5.2(26) Professional personnel who acquire the status of an officer of the state of Iowa or a political subdivision thereof, even though they engage in private practice and render government service only on a part-time basis, shall be covered.

5.2(27) Effective July 1, 1994, volunteer firefighters and special police officers are considered temporary employees and shall be covered if they meet the requirements of subrule 5.2(13).

5.2(28) Residents or inmates of county homes shall not be covered.

5.2(29) Members of the state transportation commission, the board of parole, and the state health facilities council shall be covered unless they elect out of coverage.

5.2(30) Employees of an interstate agency established under Iowa Code chapter 28E, and similar enabling legislation in an adjoining state, if the city had made contributions to the system for employees performing functions which are transferred to the interstate agency shall be considered employees of the city for the sole purpose of membership in IPERS, although the employer contributions for those employees are made by the interstate agency.

5.2(31) City managers, or city administrators performing the duties of city managers, under a form of city government listed in Iowa Code chapter 372 or 420 shall be covered unless they elect out of coverage.

5.2(32) Employees appointed by the state board of regents shall be covered unless, at the discretion of the state board of regents, they elect coverage in an alternate retirement system qualified by the state board of regents.

5.2(33) Employees who work in additional positions with additional duties, along with normal duties with the same employer, shall be considered covered employees until all of their compensated duties to their employer cease. (Examples include teacher/coach; teacher/summer driver's education instructor; and city employee/paid firefighter.)

5.2(34) Adjunct instructors employed by a community college or university shall not be covered. Adjunct instructors are persons employed by a community college or university without a continuing contract and whose teaching load does not exceed one-half time for two full semesters or three full quarters for the calendar year. The determination of whether a teaching load exceeds one-half time shall be based on the number of credit hours or noncredit contact hours that the community college or university considers to be a full-time teaching load for a regular full semester or quarter. An adjunct instructor whose teaching load exceeds the foregoing limitations shall be covered.

In determining whether an adjunct instructor is a covered employee, no credit shall be granted for teaching periods of shorter duration than a regular semester or regular quarter (such as summer semesters), regardless of the number of credit or contact hours assigned to that period.

If there is no formal severance, an adjunct instructor who becomes a covered employee shall remain a covered employee until that person completes four consecutive calendar quarters in which no services are performed for that covered employer after the last covered calendar quarter. Notwithstanding the foregoing sentence, no service credit will be granted to any adjunct instructor who has become a covered employee under this rule for any calendar quarter in which no covered wages are reported unless the adjunct instructor is on an approved leave of absence that qualifies for service credit under Iowa Code section 97B.1A(20).

5.2(35) Effective July 1, 1992, enrollees of a senior community service employment program authorized by Title V of the Older Americans Act and funded by the United States Department of Labor shall not be covered unless:

- a. Both the enrollee and the covered employer elect coverage; or
- b. The enrollee is currently contributing to IPERS.

For purposes of this subrule only, a covered employer is defined as the host agency where the enrollee is placed for training.

5.2(36) Employees of area agencies on aging shall be included. However, effective July 1, 1994, employees of area agencies on aging shall not be covered if the area agency has provided for participation by all of its eligible employees in an alternative qualified plan pursuant to the requirements of the federal Internal Revenue Code. If an area agency on aging does not participate in an alternative plan, or terminates participation in such plan, IPERS coverage shall begin immediately.

5.2(37) Effective July 1, 1994, arson investigators shall not be covered. They were transferred to the public safety peace officers' retirement, accident and disability system as found in Iowa Code chapter 97A.

5.2(38) Persons who meet the requirements of independent contractor status as determined by IPERS using the criteria established by the federal Internal Revenue Service shall not be covered.

5.2(39) Effective July 1, 1994, a person employed on or after that date for certain public safety positions shall not be covered. These positions are gaming enforcement officers employed by the division

of criminal investigation for excursion boat gambling enforcement activities, fire prevention inspector peace officers, and employees of the division of capitol police (except clerical workers).

5.2(40) Employees of area community colleges shall be covered unless they elect coverage under an alternative system pursuant to a one-time irrevocable election.

5.2(41) Volunteer emergency personnel, such as ambulance drivers, shall be considered temporary employees and shall be covered if they meet the requirements of subrule 5.2(13). Persons who meet such requirements shall be covered under the protection occupation requirements of Iowa Code section 97B.49B if they are considered firefighters by their employers; otherwise they shall be covered under Iowa Code section 97B.11.

5.2(42) Persons employed through any program described in Iowa Code section 84A.7 and provided by the Iowa conservation corps shall not be covered.

5.2(43) Appointed and full-time elective members of boards and commissions who receive a set salary shall be covered. Effective January 1, 1999, part-time elective members of boards and commissions not otherwise described in these rules who receive a set salary shall be covered unless they elect out of coverage. Members of boards, other than county boards of supervisors, and commissions, including appointed and elective full-time and part-time members, who receive only per diem and expenses shall not be covered.

5.2(44) Persons receiving rehabilitation services in a community rehabilitation program, rehabilitation center, sheltered workshop, and similar organizations whose primary purpose is to provide vocational rehabilitation services to target populations shall not be covered.

5.2(45) Persons who are members of a community service program authorized under and funded by grants made pursuant to the federal National and Community Service Act of 1990 shall not be covered.

5.2(46) Persons who are employed by professional employment organizations, temporary staffing agencies, and similar noncovered employers and are leased to covered employers shall not be covered. Notwithstanding the foregoing, persons who are employed by a covered employer and leased to a noncovered employer shall be covered.

5.2(47) Effective July 1, 1999, persons performing referee services for a covered employer shall not be covered, unless the performance of such services is included in the persons' regular job duties for the employer for which such services are performed.

5.2(48) Effective July 1, 2000, patient advocates appointed under Iowa Code section 229.19 shall be covered.

5.2(49) Employees of the Iowa student loan liquidity corporation shall not be covered.

[ARC 0662C, IAB 4/3/13, effective 5/8/13]

495—5.3(97B) Participation in IPERS and another retirement system. Effective July 1, 1996, an employee may actively participate in IPERS and another retirement system supported by public funds if the person does not receive credit under both IPERS and such other retirement system for any position held.

These rules are intended to implement Iowa Code sections 97B.1A, 97B.4, 97B.11, 97B.42, 97B.42A, 97B.49B, 97B.49C, and 97B.49G.

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CHAPTER 6
COVERED WAGES
[Prior to 6/9/04, see 581—Ch 21]

495—6.1(97B) IRS requirements. Wages as discussed in this chapter shall not exceed the amount permitted for a given year under Sections 401(a)(17)(A) and (B) of the Internal Revenue Code, which are incorporated herein by this reference.

[ARC 9397B, IAB 2/23/11, effective 3/30/11]

495—6.2(97B) Definition of wages. “Wages” means all compensation earned by employees including, except as otherwise provided under this chapter, vacation pay; sick pay; back pay; amounts deducted from the employee’s pay at the employee’s discretion for tax-sheltered annuities, dependent care and cafeteria plans; and the cash value of wage equivalents. This definition applies to these rules, regulations, interpretations, forms and other IPERS publications unless the context otherwise requires.

495—6.3(97B) IPERS coverage for various forms of compensation. The following is a list of various types of compensation and the corresponding IPERS coverage treatment:

6.3(1) *Vacation pay or annual leave pay.* Vacation pay or annual leave pay means the amount paid to an employee during a period of vacation.

6.3(2) *Sick pay.* Sick pay means payments made for sick leave which are a continuation of salary payments.

6.3(3) *Workers’ compensation payments and other third-party payments.* Workers’ compensation payments, unemployment payments, or short-term and long-term disability payments made by an insurance company or third-party payer, such as a trust, are not included as wages. Payments for sick leave which are a continuation of salary payments if paid from the employer’s general assets, regardless of whether the employer labels the payments as sick leave, short-term disability, or long-term disability, are covered wages.

6.3(4) *Compensatory time.* Wages include amounts paid for compensatory time taken in lieu of regular work hours or when paid as a lump sum. However, compensatory time paid in a lump sum shall not exceed 240 hours per employee per year or any lesser number of hours set by the employer. Each employer shall determine whether to use the calendar year or a fiscal year other than the calendar year when setting its compensatory time policy.

6.3(5) *Banked holiday pay.* If an employer codes banked holiday time as holiday or additional accrued vacation time, the banked holiday pay will be vacation pay under subrule 6.3(1). If an employer codes banked holiday time as compensatory time, the banked holiday pay will be combined with compensatory pay and subject to the limits set forth in subrule 6.3(4).

6.3(6) *Special lump sum payments.* Wages do not include special lump sum payments made during or at the end of service as a payoff of unused accrued sick leave or of unused accrued vacation. Wages do not include special lump sum payments made during or at the end of service as an incentive to retire early or as payments made upon dismissal, severance, or a special bonus payment intended as an early retirement incentive. Wages do not include: catastrophic leave paid in a lump sum, bonuses, tips or honoraria. Exclusion of payments as described in this subrule applies whether the payment is in a lump sum or in installments.

6.3(7) *Covered wage treatment for supplemental payments.*

a. Payments excluded from covered wages as bonuses include the following:

- (1) Recruitment payments.
- (2) Retention payments.
- (3) Payments to members who achieve improvements in their employer’s financial status or performance ratings.
- (4) Employee performance incentive payments.
- (5) Extraordinary job performance payments.

(6) Payments for the possession, attainment, or maintenance of special skills or professional certifications (does not apply to advancements in a member's placement in wage or salary schedule, or placement in a higher tier wage or salary schedule).

(7) Payments to members made in lieu of merit increases because the members' wage or salary scales are capped.

(8) Payments similar in substance to those enumerated above without regard to the payments' titles, tag lines, labels or classifications by employers.

b. Payments included in covered wages that are not to be treated as bonuses include the following:

(1) Payments authorized by statute and used to increase the general level of teacher pay, except as otherwise provided in this subrule (for example, when such moneys are used to pay retention bonuses).

(2) Payments for which additional, or new and different, job duties are required in order to receive the payment.

(3) Payments for employment longevity.

c. Payments that are otherwise to be treated as covered wages under paragraph "b" shall not be covered if IPERS determines that the payments are made for paragraph "a," subparagraphs (1) to (8), of this subrule or other subrules, including, but not limited to, recruitment or retention bonuses, retirement incentive and severance payments, reimbursements of business expenses, and payment of allowances.

d. IPERS shall have the final authority to determine if supplemental payments not described in paragraphs "a," "b" and "c" of this subrule should be treated as excluded bonus payments or covered wages. In making its determination, IPERS may consider, but is not limited to, such factors as the supplemental payments' similarity to payments described in paragraphs "a," "b" and "c" of this subrule, whether such payments are discretionary with the employer, and whether, on the one hand, the payments are regular and periodic over the working careers of a broad group of individuals or, on the other hand, are short-term, irregular, or ad hoc payments whose primary effect is to spike certain members' final average salaries.

6.3(8) *Other special payment arrangements.* Wages do not include amounts paid pursuant to special arrangements between an employer and employee whereby the employer pays increased wages and the employee reimburses the employer or a third-party obligor for all or part of the wage increase. This limitation includes, but is not limited to, the practice of increasing an employee's wages by the employer's share of health care costs and having the employee reimburse the employer or a third-party provider for such health care costs. Wages do not include amounts paid pursuant to a special arrangement between an employer and employee whereby wages in excess of the covered wage ceiling for a particular year are deferred to one or more subsequent years. Wages do not include employer contributions to a plan, program, or arrangement that are not included in the employee's federal taxable income. However, certain employer contributions under IRC Section 125 plans are permitted to be treated as covered wages under rule 495—6.5(97B) subject to the terms of that rule.

Employers and employees that knowingly and willfully enter into the types of arrangements described in this subrule, causing an impermissible increase in the payments authorized under Iowa Code chapter 97B, may be prosecuted under Iowa Code section 97B.40 for engaging in a fraudulent practice. If IPERS determines that its calculation of a member's monthly benefit includes amounts paid under an arrangement described in this subrule, IPERS shall recalculate the member's monthly benefit, after making the appropriate wage adjustments. IPERS may recover the amount of overpayments caused by the inclusion of the payments described in this subrule from the monthly amounts plus interest payable to the member or amounts payable to the member's successor(s) in interest, regardless of whether or not IPERS chooses to prosecute the employers and employees under Iowa Code section 97B.40.

6.3(9) *Wage equivalents.* Items such as food, lodging and transportation are includable as employee income, if they are paid as compensation for employment. The basic test is whether or not such wage equivalent was given for the convenience of the employee or employing unit. Wage equivalents are not reportable under IPERS if given for the convenience of the employing unit or are not reasonably quantifiable. Wage equivalents that are not included in the member's federal taxable income shall be deemed to be for the convenience of the employer. A wage equivalent is not reportable if the employer

certifies that there was a substantial business reason for providing the wage equivalent, even if the wage equivalent is included in the employee's federal taxable income. Wages paid in any other form than money are measured by the fair market value of the meals, lodging, travel or other wage equivalents.

6.3(10) *Members of the general assembly.* Wages for a member of the general assembly means the total compensation received by a member of the general assembly, whether paid in the form of per diem or annual salary. Wages include per diem payments paid to members of the general assembly during interim periods between sessions of the general assembly. Wages do not include expense payments except that, effective July 1, 1990, wages include daily allowances to members of the general assembly for nontravel expenses of office during a session of the general assembly. Such nontravel expenses of office during a session of the general assembly shall not exceed the maximum established by law for members from Polk County. A member of the general assembly who has elected to participate in IPERS shall receive four quarters of service credit for each calendar year during the member's term of office, even if no wages are reported in one or more quarters during a calendar year.

6.3(11) *Wages restored following an employer-mandated reduction in hours.* Notwithstanding rule 495—6.4(97B), wages restored following the receipt of contributions forwarded pursuant to 495—4.8(97B) shall be credited to quarters in which the wages would have been received but for the employer-mandated reduction in hours (EMRH).

6.3(12) *Wages paid as a back pay settlement.* IPERS contributions must be calculated on the gross amount of a back pay settlement before the settlement is reduced for taxes, interim wages, unemployment compensation, and similar mitigation of damages adjustments. IPERS contributions must be calculated by reducing the gross amount of a back pay settlement by any amounts not considered covered wages such as, but not limited to, lump sum payments for medical expenses.

Notwithstanding the foregoing, a back pay settlement that does not require the reinstatement of a terminated employee and payment of the amount of wages that would have been paid during the period of severance (before adjustments) shall be treated by IPERS as a "special lump sum payment" under subrule 6.3(6) and shall not be covered.

6.3(13) *Limitations on benefits and contributions.*

a. Section 415(b) limitations on benefits. A member may not receive an annual benefit that exceeds the dollar amount specified in Section 415(b)(1)(A) of the Internal Revenue Code, subject to the applicable adjustments in Internal Revenue Code Sections 415(b) and 415(d). For purposes of applying the limits under Internal Revenue Code Section 415(b) (Limit), the following will apply:

(1) With respect to a member who does not receive a portion of the member's annual benefit in a lump sum:

1. The member's Limit will be applied to the member's annual benefit in the first limitation year without regard to any automatic cost-of-living increases;

2. To the extent the member's annual benefit equals or exceeds the Limit, the member will no longer be eligible for cost-of-living increases under the IPERS trust fund until such time as the benefit plus the accumulated increases are less than the applicable Limit; and

3. Thereafter, in any subsequent limitation year, the member's annual benefit including any automatic cost-of-living increase shall be tested under the then applicable benefit Limit, including any adjustment to the Internal Revenue Code Section 415(b)(1)(A) dollar limit under Internal Revenue Code Section 415(d) (cost-of-living adjustments) and the regulations thereunder; and

(2) With respect to a member who receives a portion of the member's annual benefit in a lump sum:

1. The member's applicable Limit shall be applied taking into consideration automatic cost of living increases as required by Internal Revenue Code Section 415(b) and applicable Treasury Regulations; and

2. In no event shall a member's annual benefit payable under the system in any limitation year be greater than the Limit applicable at the annuity starting date, as increased in subsequent years pursuant to Internal Revenue Code Section 415(d) and the regulations thereunder. If the form of benefit without regard to the automatic benefit increase feature is not a straight life or a qualified joint and survivor annuity, then the preceding sentence is applied by either reducing the Limit applicable at the annuity starting date or adjusting the form of benefit to an actuarially equivalent straight life annuity benefit

determined using the assumptions required by Treasury Regulations, including the mortality table specified in Revenue Ruling 2001-62 or Revenue Ruling 2007-67, as applicable.

b. Section 415(c) limitations on contributions and other member additions. Member contributions and other additions paid to the system may not exceed the annual limits on contributions and other additions allowed by Internal Revenue Code Section 415(c). For purposes of applying these limits, the definition of “compensation,” where applicable, will be compensation as defined in Treasury Regulation Section 1.415(c)-2(d)(3), or successor regulation. The foregoing definition of compensation will exclude member contributions picked up under Internal Revenue Code Section 414(h)(2) and, for plan years beginning after December 31, 1997, compensation will include the amount of any elective deferrals, as defined in Internal Revenue Code Section 402(g)(3), and any amount contributed or deferred by the employer at the election of the member and which is not includible in the gross income of the member by reason of Internal Revenue Code Section 125 or 457 and, for plan years beginning on and after January 1, 2001, pursuant to Internal Revenue Code Section 132(f)(4).

c. Limitation year. The limitation year is the calendar year.

6.3(14) *Employer payments treated as remuneration counted against the reemployment earnings limit.* All taxable or nontaxable compensation, regardless of the title, tag line, label, or classification attributed to that compensation paid by IPERS-covered employers to retired reemployed IPERS members, shall be considered remuneration when determining reemployment earnings limits and reductions as set forth under Iowa Code section 97B.48A and rule 495—12.8(97B). This rule shall apply whether the compensation is paid pursuant to individual contracts or otherwise, and regardless of whether it is considered covered or noncovered compensation under Iowa Code section 97B.1A(26) and the administrative rules thereunder, except for:

- a.* Contributions to health insurance plans and programs, and
- b.* Reimbursements of actual work-related expenses required by the retired reemployed members’ jobs.

6.3(15) *Employer contributions as remuneration counted against the reemployment earnings limit.* Employer contributions made on behalf of retired reemployed members to tax qualified and nonqualified retirement and deferred compensation plans and to other fringe benefit arrangements, excluding health insurance plans and programs, shall constitute remuneration from employment which shall be applied to the reemployment earnings limits and reductions set forth under rule 495—12.8(97B). Such contributions, even if counted as remuneration hereunder, shall not be counted as covered wages, unless the facts in the particular case indicate that, under the circumstances, the arrangement should be treated as covered wages under rules 495—6.1(97B) through 495—6.5(97B). Nonelective employer contributions to the following shall constitute remuneration when determining reemployment earnings limits: tax qualified retirement and deferred compensation plans; all nonqualified retirement plans and deferred compensation arrangements; IRAs; rabbi, secular, and other trust arrangements; split dollar and other life insurance arrangements; and long-term care insurance.

[ARC 7759B, IAB 5/6/09, effective 4/17/09; ARC 7916B, IAB 7/1/09, effective 8/5/09]

495—6.4(97B) Month for which wages are to be reported. Wages are reportable for the month in which they are actually paid to the employee, except when employees are awarded lump sum payments of back wages, whether as a result of litigation or otherwise, receive lump sum payments of extra duty pay, or request wage restorations following EMRH, and similar situations involving regular and periodic lump sum payments which IPERS in its sole discretion determines should be treated as covered wages. The employer shall file wage adjustment reporting forms with IPERS allocating the wages to the periods of service for which such payments are awarded. Employers shall forward the required employer and employee contributions and interest to IPERS.

6.4(1) *Actual and constructive receipt.* An employer cannot report wages as having been paid to employees as of a monthly reporting date if the employee has not actually or constructively received the payments in question. For example, wages that are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on June 30 would be reported as June wages, but wages that

are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on July 3 would be reported as July wages.

6.4(2) One quarter of service will be credited for each quarter in which a member is paid IPERS covered wages.

a. “Covered wages” means wages of a member during periods of service that do not exceed the annual covered wage maximum as permitted for a given year under Sections 401(a)(17)(A) and (B) of the Internal Revenue Code, which are incorporated herein by this reference.

b. Effective January 1, 1988, covered wages shall include wages paid a member regardless of age. (From July 1, 1978, until January 1, 1988, covered wages did not include wages paid a member on or after the first day of the month in which the member reached the age of 70.)

c. If a member is employed by more than one employer during the calendar year, the total amount of wages paid by all covered employers shall be included in determining the annual covered wage limit established under Sections 401(a)(17)(A) and (B) of the Internal Revenue Code. If the amount of wages paid to a member by several employers during any given month exceeds the covered wage limit as determined for that calendar year, the amount of the excess shall not be subject to contributions required by Iowa Code section 97B.11. IPERS shall not accept excess wages and applicable contributions from employers and shall return excess contributions as provided in 495—subrule 4.3(8).

[ARC 7759B, IAB 5/6/09, effective 4/17/09; ARC 7916B, IAB 7/1/09, effective 8/5/09; ARC 9397B, IAB 2/23/11, effective 3/30/11]

495—6.5(97B) Covered wage treatment for employer contributions to IRC Section 125 plans. If certain conditions are met, employer contributions to fringe benefit programs that qualify under IRC Section 125 may be treated as covered wages. The following subrules set forth IPERS’ regulations for determining covered wage treatment and for making wage adjustments when employer-paid contributions have been covered or excluded in violation of the standards set forth below.

6.5(1) Section 125 plans. For purposes of this rule, a Section 125 plan means an employer-sponsored fringe benefit plan that is subject to Section 125 of the federal Internal Revenue Code. Some of the common names for this type of plan are cafeteria plan, flexible benefits plan, flex plan, and flexible spending arrangement.

6.5(2) Elective employer contributions. For purposes of this rule, “elective employer contributions” means employer contributions made to a Section 125 plan that can be received in cash or used to purchase benefits under the Section 125 plan. Generally, elective employer contributions that are not subject to special eligibility requirements qualify as covered wages.

6.5(3) Mandatory minimum coverage requirements. The term “elective employer contributions” does not include employer contributions that must be used to purchase benefits under a Section 125 plan. For example, if an employer provides \$2,500 to its employees to purchase benefits in a Section 125 plan, but requires that all employees must use \$1,000 of that amount to purchase single health coverage, the cost of the single coverage is deducted. In this example, \$1,000 would be subtracted from the \$2,500 provided, resulting in \$1,500 of covered wages.

6.5(4) Uniformity determined coverage group by coverage group. Iowa Code section 97B.1A(26)“a”(1)“b” states that elective employer contributions shall be treated as covered wages only if made uniformly available and not limited to highly compensated employees. The application of the uniformity concept may be illustrated as follows: Employer Z has two major groupings of employees covered under its cafeteria plan: teaching staff and support staff. Every member of the teaching staff is provided \$3,000 to purchase benefits under the Section 125 plan. Every member of the teaching staff must take single coverage costing \$1,500. Every member of the support staff is provided \$2,500 and must also take the single coverage costing \$1,500. Each member of the teaching staff would have \$1,500 treated as covered wages, and each member of the support staff would have \$1,000 treated as covered wages. This would be considered uniform treatment.

Uniformity is not destroyed by the fact that the amount available to members of a coverage group varies because the actual cost of mandatory minimum coverage varies depending on actuarial factors that apply to each individual. For example, assume Employer Z above also requires each employee to have long-term disability coverage. In Employer Z’s case, the actual cost of disability coverage will vary

from individual to individual. In that case, Employer Z would also deduct the actual cost of the required disability coverage, individual by individual, when determining IPERS covered wages.

Uniformity is not destroyed if an employer has two groups of employees who, as a result of collective bargaining, have differing entitlements to employer contributions. For example, Employer Y has a contract that provides \$3,500 to each employee to purchase benefits under the Section 125 plan. Every employee may take all the cash by waiving participation in the plan, or may use all or part of the employer contributions to the Section 125 plan. In the collective bargaining process, a new contract is adopted which states that the employer will still provide \$3,500 to each employee to purchase benefits under the Section 125 plan. However, under the new contract, persons who waived participation before April 15 may still waive participation in the plan and take all the cash, but persons who did not waive participation and those hired after April 15 must have single coverage costing \$1,700. Employer Y would be treated as having two groups of employees with different elective employer contribution amounts. The grandfathered group (employees who waived participation before April 15) would have covered wages of \$3,500, and the group consisting of those who did not waive participation before April 15 and new employees would have covered wages of \$1,800.

6.5(5) *Highly compensated employee test.* Iowa Code chapter 97B provides that, in addition to being uniformly available, employer contributions must not discriminate in favor of highly compensated employees (HCEs). For purposes of this subrule, an HCE is an employee who has reported wages and tips subject to Medicare tax in excess of the IRC Section 414(q) limit then in effect. IPERS shall apply the HCE limitation as follows. If elective employer contributions are made available to HCEs, the total elective employer contributions made available to the HCE group must not exceed 25 percent of the total elective employer contributions made available under the Section 125 plan to all employees, including the HCEs. If the elective employer contributions available to the HCE group exceed the 25 percent limit (or if it is determined that the Section 125 plan discriminates in favor of HCEs under other IRS rules), elective employer contributions for HCEs shall not exceed the highest amount available to a nonexecutive coverage group of employees covered under such plan. The general application of these principles is illustrated below, using the 2002 IRC Section 414(q) dollar limit of \$90,000.

Employer W has a Section 125 plan that provides elective employer contributions totaling \$7,000 to executive staff, \$4,500 to teaching staff, and \$3,500 to support staff. There are no other limits or exclusions that apply. These amounts are treated as covered wages for each member of each group, provided that the total amount of contributions made available to HCEs does not exceed 25 percent of the total elective employer contributions for all employees covered under the plan. If elective employer contributions for the executive staff totaled \$70,000, and total elective employer contributions for the remainder of the staff totaled \$500,000, the HCE percentage of total elective employer contributions would be 12 percent (\$70,000 divided by \$570,000), and all elective employer contributions would be treated as covered wages for all groups. However, if elective employer contributions for the executive staff totaled \$70,000, and elective employer contributions for the remainder of the staff totaled \$200,000, the HCE percentage would be 26 percent (\$70,000 divided by \$270,000), and HCEs' elective employer contributions would be limited to \$4,500 per HCE for covered wage purposes.

6.5(6) *Elective employer contributions limited to dual coverage employees.* In some cases, a Section 125 plan provides for what appear to be mandatory employer contributions for health plan coverage, but the terms of the Section 125 plan permit dual coverage employees to waive coverage and receive the employer contributions in cash, if the employee can prove coverage under another health care plan. IPERS shall continue to treat the full amount of employer contributions in such cases as not being IPERS covered wages, even though individual employees with the described dual coverage may actually receive the employer contribution in cash.

6.5(7) *Corrections for overpayments and underpayments of contributions and benefits caused by Section 125 plan covered wage errors.* IPERS shall use the following guidelines in requiring corrections for overpayments and underpayments of contributions and benefits caused by the erroneous inclusion or exclusion of employer contributions to a Section 125 plan. Corrections must be made for all active, terminated and retired members, subject to the following limitations:

a. If elective employer contributions that should have been covered were not covered, wage adjustments shall be filed, and employers shall be billed for all shortages plus interest. Employers shall be entitled to collect reimbursement for the employee share of contributions as provided in Iowa Code section 97B.9. If retirement benefits, death benefits or refunds have been underpaid as a result of the error, IPERS shall, upon receipt of the contribution shortage, make the appropriate adjustments and pay all back benefits.

b. If employer contributions that should not have been covered were covered, wage adjustments shall be filed, and the appropriate contribution amounts shall be repaid to employers for distribution to the respective employee and employer contributors. If the reporting error caused an overpayment of retirement benefits, death benefits, or refunds, IPERS shall offset excess contributions received against overpayments and shall request a repayment of the remainder of the overpayment, if any, from the recipient.

Wage adjustments, overpayments, and underpayments and unintentional reporting errors shall be determined as of the onset of the error, but shall be limited to three years before the beginning of the current contract year for school employers, or current fiscal year for all other covered employers. IPERS may go back to the onset of the error, even if the period exceeds three years, if the error is caused by intentional misconduct or gross neglect. Notwithstanding the foregoing adjustment and collection standards, IPERS reserves the right to negotiate adjustments with individual employers in special situations, and no negotiated settlement with an employer shall be deemed to constitute a waiver of this rule or a binding precedent for other employers.

6.5(8) Bounties.

a. Effective prior to June 21, 2010, in some cases, an employer has a Section 125 plan with employer contributions, and what IPERS refers to as a bounty option. A bounty is an amount that may be elected by all employees, or by a subset of that group, such as employees with coverage under another health care plan, either in lieu of any coverage under the employer's health care plan, or in lieu of family coverage. A bounty is generally set at an amount that is less than the amount that would otherwise be available to purchase benefits under the Section 125 plan. IPERS does not treat bounties as covered wages. The uniformity and nondiscrimination principles described in subrule 6.5(4) do not apply to such benefits.

b. Paragraph “*a*” no longer applies effective June 21, 2010. An employer that has relied on the bounty rule to exclude bounty payments from covered wages shall have until September 1, 2010, to bring payroll processes and prospective wage coverage into compliance. No retroactive adjustment shall be required for employers that relied on paragraph “*a*” for periods prior to September 1, 2010.

[ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10]

These rules are intended to implement Iowa Code sections 97B.1A(26), 97B.9, 97B.11, 97B.14 and 97B.14A.

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CHAPTER 11
APPLICATION FOR, MODIFICATION OF, AND TERMINATION OF BENEFITS

[Prior to 11/24/04, see 581—Ch 21]

495—11.1(97B) Application for benefits.

11.1(1) *Form used.* It is the responsibility of the member to notify IPERS of the intention to retire. This should be done 60 days before the expected retirement date. The application for monthly retirement benefits is obtainable from IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117. The printed application form shall be completed by each member applying for benefits and shall be mailed, sent by fax or brought in person to IPERS. An application that is incomplete or incorrectly completed will be returned to the member. To be considered complete, an application must include the following:

- a. Proof of date of birth for the member.
- b. Option selected, and
 - (1) If Option 1 is selected, the death benefit amount.
 - (2) If Option 4 or 6 is selected, the contingent annuitant's name, gender, social security number, proof of date of birth, and relationship to member.
 - (3) If Option 1, 2, or 5 is selected, a list of beneficiaries.
- c. If the member is disabled, a copy of the award letter from social security or railroad retirement and a statement that the member is retiring due to disability.
- d. If the member has been terminated less than one year, the employer certification page must be completed by the employer.
- e. Signature of member and spouse, both properly notarized.
- f. If the member has no spouse, "NONE" must be designated.

A retirement application is deemed to be valid and binding when the first payment is paid. Members shall not cancel their applications, change their option choice, or change an IPERS option containing contingent annuitant benefits after that date.

11.1(2) *Proof required in connection with application.* Proof of date of birth to be submitted with an application for benefits shall be in the form of a birth certificate or an infant baptismal certificate. If these records do not exist, the applicant shall submit two other documents or records which will verify the day, month and year of birth. A photographic identification record may be accepted even if now expired unless the passage of time has made it impossible to determine if the photographic identification record is that of the applicant. The following records or documents are among those deemed acceptable to IPERS as proof of date of birth:

- a. United States census record;
- b. Military record or identification card;
- c. Naturalization record;
- d. A marriage license showing age of applicant in years, months and days on date of issuance;
- e. A life insurance policy;
- f. Records in a school's administrative office;
- g. An official form from the United States Immigration and Naturalization Service, such as the "green card," containing such information;
- h. Driver's license or Iowa nondriver identification card;
- i. Adoption papers;
- j. A family Bible record. A photostatic copy will be accepted with certification by a notary that the record appears to be genuine; or
- k. Any other document or record ten or more years old, or certification from the custodian of such records which verifies the day, month, and year of birth.

If the member, the member's representative, or the member's beneficiary is unable or unwilling to provide proof of birth, or in the case of death, proof of death, IPERS may rely on such resources as it has available, including but not limited to records from the Social Security Administration, Iowa division

of records and statistics, IPERS' own internal records, or reports derived from other public records, and other departmental or governmental records to which IPERS may have access.

IPERS is required to begin making payments to a member or beneficiary who has reached the required beginning date specified by Internal Revenue Code Section 401(a)(9). In order to begin making such payments and to protect IPERS' status as a plan qualified under Internal Revenue Code Section 401(a), IPERS may rely on its internal records with regard to date of birth, if the member or beneficiary is unable or unwilling to provide the proofs required by this subrule within 30 days after written notification of IPERS' intent to begin mandatory payments.

11.1(3) *Benefits estimates.* Prior to submitting an application for benefits, a member may request IPERS to prepare estimates of projected benefits under the various options as described under Iowa Code section 97B.51. A benefit estimate shall not bind IPERS to payment of the projected benefits under the various options specified in Iowa Code chapter 97B. A member cannot rely on the benefit estimate in making any retirement-related decision or taking any action with respect to the member's account, nor shall IPERS assume any liability for such actions. A member's actual benefit can only be known and officially calculated when an eligible member applies for benefits.

11.1(4) *Revocation of application.* If IPERS determines an application for benefits is invalid for any reason, IPERS shall revoke, in whole or in pertinent part, the application for benefits and the recipient shall repay all payments made under the revoked application or all payments made pursuant to the revoked part of the application. The terms of repayment shall be subject to the provisions of 495—11.7(97B).

[ARC 8601B, IAB 3/10/10, effective 4/14/10]

495—11.2(97B) Retirement benefits and the age reduction factor.

11.2(1) *Normal retirement.*

a. A member shall be eligible for monthly retirement benefits with no age reduction effective with the first of the month in which the member attains the age of 65, if otherwise eligible.

b. Effective July 1, 1998, a member shall be eligible for full monthly retirement benefits with no age reduction effective with the first of the month in which the member attains the age of 62, if the member has 20 full years of service and is otherwise eligible.

c. Effective July 1, 1997, a member shall be eligible to receive monthly retirement benefits with no age reduction effective the first of the month in which the member's age on the last birthday and the member's years of service equal or exceed 88, provided that the member is at least the age of 55 and is otherwise eligible.

11.2(2) *Early retirement.* A member shall be eligible to receive benefits for early retirement effective with the first of the month in which the member attains the age of 55 or the first of any month after attaining the age of 55 before the member's normal retirement date, provided the date is after the last day of service and the member is otherwise eligible.

11.2(3) *Aged 70 and older retirees.* A member shall be eligible to receive monthly retirement benefits with no age reduction effective with the first day of the month in which the member attains the age of 70, even if the member continues to be employed.

11.2(4) *Required beginning date.*

a. Notwithstanding the foregoing, IPERS shall commence payment of a member's retirement benefit under Iowa Code sections 97B.49A to 97B.49I (under Option 2) no later than the "required beginning date" specified under Internal Revenue Code Section 401(a)(9), even if the member has not submitted the application for benefits. If the lump sum actuarial equivalent could have been elected by the member, payments shall be made in such a lump sum rather than as a monthly allowance. The "required beginning date" is defined as the later of: (1) April 1 of the year following the year that the member attains the age of 70½, or (2) April 1 of the year following the year that the member actually terminates all employment with employers covered under Iowa Code chapter 97B.

b. If IPERS distributes a member's benefits without the member's consent in order to begin benefits on or before the required beginning date, the member may elect to receive benefits under an option other than the default option described above, or as a refund, if the member contacts IPERS

in writing within 60 days of the first mandatory distribution. IPERS shall inform the member which adjustments or repayments are required in order to make the change.

c. If a member cannot be located to commence payment on or before the required beginning date described above, the member's benefit shall be forfeited. However, if a member later contacts IPERS and wishes to file an application for retirement benefits, the member's benefits shall be reinstated.

d. For purposes of determining benefits, the life expectancy of a member, a member's spouse, or a member's beneficiary shall not be recalculated after benefits commence.

e. If an IPERS member has a qualified domestic relations order (QDRO) or an administrable domestic relations order (ADRO) on file when a mandatory distribution is required, and the QDRO or ADRO requires the member to choose a specific retirement option, IPERS shall pay benefits under the option required by the order.

11.2(5) *Mandatory distribution of small inactive accounts.* As soon as practicable after July 1, 2004, IPERS shall distribute small inactive accounts to members and beneficiaries as authorized in Iowa Code section 97B.48(5).

11.2(6) *Federal tax code limitation for selection of survivor percentages for same gender spouses.* Benefits payable to members who name a same gender spouse or same gender former spouse as contingent annuitant under Option 4 or 6 shall be subject to the incidental death benefit limitations of Internal Revenue Code Section 401(a)(9)(G).

[ARC 8601B, IAB 3/10/10, effective 4/14/10]

495—11.3(97B) First month of entitlement (FME).

11.3(1) *General.* A member shall submit a written application to IPERS setting forth the retirement date, provided the member has attained at least age 55 by the retirement date and the retirement date is after the member's last day of service. A member's first month of entitlement shall be no earlier than the first day of the first month after the member's last day of service or, if later, the month provided for under subrule 11.3(2). No payment shall be made for any month prior to the month the completed application for benefits is received by IPERS.

If a member files a retirement application but fails to select a valid first month of entitlement, IPERS will select by default the earliest month possible. A member may appeal this default selection by sending written notice of the appeal postmarked on or before 30 days after a notice of the default selection was mailed to the member. Notice of the default selection is deemed sufficient if sent to the member at the member's address.

11.3(2) *Additional FME provisions.*

a. Effective through December 31, 1992, the first month of entitlement of a member who qualifies for retirement benefits is the first month following the member's date of termination or last day of leave, with or without pay, whichever is later.

b. Effective January 1, 1993, the first month of entitlement of an employee who qualifies for retirement benefits shall be the first month after the employee is paid the last paycheck, if paid more than one calendar month after termination. If the final paycheck is paid within the month after termination, the first month of entitlement shall be the month following termination.

c. Effective January 1, 2001, employees of a school corporation who are permitted by the terms of their employment contracts to receive their annual salaries in monthly installments over periods ranging from 9 to 12 months may retire at the end of a school year and receive trailing wages through the end of the contract year if they have completely fulfilled their contract obligations at the time of retirement. For purposes of this paragraph, "school corporation" means body politic described in Iowa Code sections 260C.16 (community colleges), 273.2 (area education agencies) and 273.1 (K-12 public schools). For purposes of this paragraph, "trailing wages" means previously earned wage payments made to such employees of a school corporation after the first month of entitlement. This exception does not apply to hourly employees, including those who make arrangements with their employers to hold back hourly wages for payment at a later date, to employees who are placed on sick or disability leave or leave of absence, or to employees who receive lump sum leave, vacation leave, early retirement incentive pay or any other lump sum payments in installments.

For all employees of all IPERS covered employers who terminate employment in January 2003, or later, if the final paycheck is paid within the same quarter or within one quarter after termination and wages are reported under the normal pay schedule, the first month of entitlement shall be the month following termination. However, if the last paycheck is paid more than one quarter after the termination, the first month of entitlement shall be the first month after the employee is paid the last paycheck. Under no circumstances shall such trailing wages result in more than one quarter of service credit being added to retiring members' earning records.

11.3(3) *Survival into designated FME.* To be eligible for a monthly retirement benefit, the member must survive into the designated first month of entitlement. If the member dies prior to the first month of entitlement, the member's application for monthly benefits is canceled and the distribution of the member's account is made pursuant to Iowa Code section 97B.52. Cancellation of the application shall not invalidate a beneficiary designation. If the application is dated later in time than any other designations, IPERS will accept the designation in a canceled application as binding until a subsequent designation is filed.

11.3(4) *Members retiring under the rule of 88.* The first month of entitlement of a member qualifying under the rule of 88 shall be the first of the month when the member's age as of the last birthday and years of service equal 88. The fact that a member's birthday allowing a member to qualify for the rule of 88 is the same month as the first month of entitlement does not affect the retirement date.

495—11.4(97B) Termination of monthly retirement allowance. A member's retirement benefit shall terminate after payment is made to the member for the entire month during which the member's death occurs. Death benefits shall begin with the month following the month in which the member's death occurs.

Upon the death of the retired member, IPERS will reconcile the decedent's account to determine if an overpayment was made to the retired member and if further payment(s) is due to the retired member's named beneficiary, contingent annuitant, heirs at law or estate. If an overpayment has been made to the retired member, IPERS will determine if steps should be taken to seek collection of the overpayment from the named beneficiary, contingent annuitant, estate, heirs at law, or other interested parties.

495—11.5(97B) Bona fide retirement and bona fide refund.

11.5(1) *Bona fide retirement—general.* To receive retirement benefits, a member under the age of 70 must officially leave employment with all IPERS covered employers, give up all rights as an employee, and complete a period of bona fide retirement. A period of bona fide retirement means four or more consecutive calendar months for which the member qualifies for monthly retirement benefit payments. The qualification period begins with the member's first month of entitlement for retirement benefits as approved by IPERS. A member may not return to covered employment before filing a completed application for benefits. Notwithstanding the foregoing, the continuation of group insurance coverage at employee rates for the remainder of the school year for a school employee who retires following completion of services by that individual shall not cause that person to be in violation of IPERS' bona fide retirement requirements.

A member will not be considered to have a bona fide retirement if the member is a school or university employee and returns to work with the employer after the normal summer vacation. In other positions, temporary or seasonal interruption of service which does not terminate the period of employment does not constitute a bona fide retirement. A member also will not be considered to have a bona fide retirement if the member has, prior to or during the member's first month of entitlement, entered into contractual arrangements with the employer to return to employment after the expiration of the four-month bona fide retirement period.

Effective July 1, 1990, a school employee will not be considered terminated if, while performing the normal duties, the employee performs for the same employer additional duties which take the employee beyond the expected termination date for the normal duties. Only when all the employee's compensated duties cease for that employer will that employee be considered terminated.

The bona fide retirement period will be waived, however, if the member is elected to public office which term begins during the normal four-month bona fide retirement period. This waiver does not apply if the member was an elected official who was reelected to the same position for another term. The bona fide retirement period will also be waived for state legislators who terminate their nonlegislative employment and the IPERS coverage for their legislative employment and begin retirement but wish to continue with their legislative duties.

A member will have a bona fide retirement if the member returns to work as an independent contractor with a public employer during the four-month qualifying period. Independent contractors are not covered under IPERS.

Effective July 1, 1998, through June 30, 2000, a member does not have a bona fide retirement until all employment with covered employers, including employment which is not covered by 495—Chapter 4, is terminated and the member receives at least four monthly benefit payments. In order to receive retirement benefits, the member must file a completed application for benefits with IPERS before returning to any employment with the same employer.

Effective July 1, 2000, a member does not have a bona fide retirement until all employment with covered employers, including employment which is not covered under this chapter, is terminated for at least one month, and the member does not return to covered employment for an additional three months. In order to receive retirement benefits, the member must file a completed application for benefits before returning to any employment with a covered employer.

11.5(2) *Bona fide retirement—licensed health care professionals.* For retirees whose first month of entitlement is no earlier than July 2004 and no later than June 2014, a retiree who is reemployed as a “licensed health care professional” by a “public hospital” does not have a bona fide retirement until all employment with covered employers is terminated for at least one calendar month. In order to receive retirement benefits, the member must file a completed application for benefits form before returning to any employment with a covered employer.

“Licensed health care professional” means a public employee who is a physician, surgeon, podiatrist, osteopath, psychologist, physical therapist, physical therapist assistant, nurse, speech pathologist, audiologist, occupational therapist, respiratory therapist, pharmacist, social worker, dietitian, mental health counselor, or physician assistant who is required to be licensed under Iowa Code chapter 147.

“Public hospital” means a governmental entity of a political subdivision of the state of Iowa that is authorized by legislative authority. For purposes of this subrule, a “public hospital” must also meet the requirements of Iowa Code section 249J.3. Under Iowa Code section 249J.3, a “public hospital” must be licensed pursuant to Iowa Code chapter 135B and governed pursuant to Iowa Code chapter 145A(merged hospitals), Iowa Code chapter 347 (county hospitals), Iowa Code chapter 347A (county hospitals payable from revenue), or Iowa Code chapter 392 (creation by city of a hospital or health care facility). For the purposes of this definition, “public hospital” does not include a hospital or medical care facility that is funded, operated, or administered by the Iowa department of human services, Iowa department of corrections, or board of regents, or the Iowa Veterans Home.

A “public hospital” possesses the powers conferred upon it by statute, the Iowa Constitution, and regulatory provisions that are unique to governmental entities and hospitals. For example, a “public hospital” may finance its activities by tax levies or the issuance of bonds, condemn property, hold elections, and join forces with other governmental entities in cooperative ventures that are authorized under Iowa Code chapter 28D and Iowa Code chapter 28E. “Public hospitals” are subject to scrutiny by the public by complying with Iowa Code chapter 21 (open meetings Act) and Iowa Code chapter 22(open records Act). Public employees of a “public hospital” are covered by Iowa Code chapter 20 (public employment relations Act). A “public hospital” can be distinguished from a profit or not-for-profit hospital by examining whether the focus of the hospital is community service with profits being applied not to rates of return to investors, but to enhance community services, facility upgrading, or subsidized care for persons unable to pay the full cost of service.

This subrule only applies to reemployments that meet all the foregoing requirements and in addition occur following a “complete termination of employment.” A “complete termination of employment” means: (1) the employer must post the opening and conduct a job search; (2) the retired member must

receive all termination payouts that are mandatory for other terminated employees of that employer; (3) the retired member must give up all perquisites of seniority, to the extent applicable to all other terminated employees of that employer; and (4) the retired member must not enter into a reemployment agreement with the prior employer or another public hospital as defined in this subrule prior to or during the first month of entitlement.

11.5(3) *Bona fide refund.* The 30-day bona fide refund period shall be waived for an elected official covered under Iowa Code section 97B.1A(8) “a”(1), and for a member of the general assembly covered under Iowa Code section 97B.1A(8) “a”(2), when the elected official or legislator notifies IPERS of the intent to terminate IPERS coverage for the elective office and, at the same time, terminates all other IPERS covered employment prior to the issuance of the refund. Such an official may remain in the elective office and receive an IPERS refund without violating IPERS’ bona fide refund rules. If such elected official terminates coverage for the elective office and also terminates all other IPERS covered employment but is then reemployed in covered employment, and has not received a refund as of the date of hire, the refund shall not be made. Furthermore, if such elected official is reemployed in covered employment, the election to revoke IPERS coverage for the elective position shall remain in effect, and the public official shall not be eligible for new IPERS coverage for such elected position.

The prior election to revoke IPERS coverage for the elected position shall also remain in effect if such elected official is reelected to the same position without an intervening term out of office. The waiver granted in this subrule shall be applicable to such elected officials who were in violation of the prior bona fide refund rules on and after November 1, 2002, when such individuals have not repaid the previously invalid refund.

If a member takes a refund in violation of the bona fide refund requirements of Iowa Code section 97B.53(4), the member shall have 30 days from the date of written notice by IPERS to repay the refund in full without interest. Thereafter, in order to receive service credit for the period covered by the refund, the member shall be required to buy back the period of service at its full actuarial cost.

11.5(4) *Part-time appointed members of boards or commissions receiving minimal noncovered wages.* Solely for purposes of determining whether a member has severed all employment with all covered employers and has remained out of employment as required under Iowa Code section 97B.52A, persons who have been appointed as part-time members of boards or commissions prior to or during their first month of entitlement and who receive only per diem and reimbursements for reasonable business expenses for such positions will be deemed not to be in employment prohibited under Iowa Code section 97B.52A.

For purposes of this subrule, per diem shall not exceed the amount authorized under Iowa Code section 7E.6(1) “a” for members of boards, committees, commissions, and councils within the executive branch of state government. This limit shall apply regardless of whether or not the position in question is within the executive branch of state government.

Members of boards and commissions not exempted under this subrule include: (a) those who are entitled to the payment of per diem regardless of attendance at board or commission meetings, and (b) those who would have received per diem in excess of the amount authorized under Iowa Code section 7E.6(1) “a” were it not for an agreement by the member to waive such compensation.

Persons appointed as part-time board or commission members who receive only per diem as set forth above and reimbursements of reasonable business expenses may continue in or accept appointments to such positions without violating the bona fide retirement rules under Iowa Code section 97B.52A.

11.5(5) *Members of the national guard who are called into state active duty.* Effective May 25, 2008, members of the national guard who are called into state active duty as defined in Iowa Code section 29A.1 in noncovered positions during the required period of complete severance will not be in violation of the bona fide retirement requirements of Iowa Code section 97B.52A as amended by 2010 Iowa Acts, House File 2518, section 33.

[ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10; ARC 0662C, IAB 4/3/13, effective 5/8/13]

495—11.6(97B) Payment processing and administration.

11.6(1) *Monthly paper warrants processing fee.* Effective July 1, 2005, IPERS shall charge a per-warrant processing fee to members who choose to receive paper warrants in lieu of electronic deposits of their monthly retirement allowance. The fee may be waived if the person establishes that it would be an undue hardship for the person to do what is necessary to receive payment of the person's IPERS monthly retirement allowance by electronic deposit. The processing fee will be deducted from the member's retirement allowance on a posttax basis.

For purposes of this subrule, a member claiming undue hardship must establish that the cost normally assessed for the processing of paper warrants would be unduly burdensome because of the member's limited income, or is otherwise financially burdensome or physically impracticable.

11.6(2) *Repeated requests for replacement warrants.* Effective July 1, 2002, for a member or beneficiary who, due to the member's or beneficiary's own actions or inactions, has benefits warrants replaced twice in a six-month period, except when the need for a replacement warrant is caused by IPERS' failure to mail to the address specified by the recipient, payment shall be suspended until such time as the recipient establishes a direct deposit account in a bank, credit union or similar financial institution and provides IPERS with the information necessary to make electronic transfer of said monthly payments. Persons subject to said cases may be required to provide a face-to-face interview and additional documentation to prove that such a suspension would result in an undue hardship.

11.6(3) *Forgery claims.* When a forgery of a warrant issued in payment of an IPERS refund or benefit is alleged, the claimant must complete and sign an affidavit before a notary public that the endorsement is a forgery. A supplementary statement must be attached to the affidavit setting forth the details and circumstances of the alleged forgery.

11.6(4) *Rollover fees.* Effective January 1, 2007, if the recipient of a lump-sum distribution which qualifies to be rolled over requests that a rollover be made to more than one IRA or other qualified plan, IPERS may assess a \$5 administrative fee for each additional rollover beyond the first one. The fee will be deducted from the gross amount of each distribution, less federal and state income tax.

11.6(5) *Offsets against amounts payable.* IPERS may, with or without consent and upon reasonable proof thereof, offset amounts currently payable to a member or the member's designated beneficiaries, heirs, assigns or other successors in interest by the amount of IPERS benefits paid in error to or on behalf of such member or the member's designated beneficiaries, heirs, assigns or other successors in interest.

11.6(6) *Lump sum paper warrants processing fee.* Effective April 1, 2012, and thereafter, IPERS shall charge \$1 for paper warrants issued in payment of all nonrecurring lump sum distributions. If a nonrecurring lump sum distribution is followed by a supplemental lump sum distribution due to the reporting of additional covered wages, the \$1 processing fee shall also be charged. This \$1 processing fee shall not apply to a direct rollover described under Iowa Code section 97B.53B (however, processing fees may be charged for multiple rollover requests), lump sum mandatory account distributions required under Iowa Code section 97B.48(5), mandatory lump sum distributions required under Internal Revenue Code Section 401(9), or warrants reissued in forged endorsement or other fraudulent payment situations. [ARC 0017C, IAB 2/22/12, effective 3/28/12]

495—11.7(97B) Overpayment of IPERS benefits.**11.7(1) *Overpayments—general.***

a. An "overpayment" means a payment of money by IPERS that results in a recipient receiving a higher payment than the recipient is entitled to under the provisions of Iowa Code chapter 97B.

b. A "recipient" is a person or beneficiary, heir, assign, or other successor in interest who receives an overpayment from an IPERS benefit and is liable to repay the amount(s) upon receipt of a written explanation and request for the amounts to be repaid.

c. If IPERS determines that the cost of recovering the amount of an overpayment is estimated to exceed the overpayment, the repayment may be deemed to be unrecoverable.

d. If the overpayment is equal to or less than \$50 and cannot be recovered from other IPERS payments, IPERS may limit its recovery efforts to written requests for repayment and other nonjudicial remedies.

11.7(2) *Overpayment made to a retired member.* A retired member shall receive written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and a limited opportunity to repay the overpayment in full without interest. If a retired member repays an overpayment in full within 30 days after the date of the notice, there will be no interest charge. A retired member may repay an overpayment out of pocket or direct IPERS to recover the overpayment from future retirement benefit payments, or a combination of both. If the retired member cannot repay an overpayment in full, either out of pocket or from the next monthly installment of retirement benefits, or both, interest shall be charged. A retired member who cannot repay the full amount of the overpayment within 30 days after the date of the notice must enter into an agreement with IPERS to make monthly installment payments, or to have the overpayment offset against future monthly benefit payments or death benefits, if any, and authorize any unpaid balance as a first priority claim in the recipient's estate.

11.7(3) *Overpayment made to a person other than a retired member.* A recipient other than a retired member, except a recipient listed in subrule 11.7(4), shall receive written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and the opportunity to repay the overpayment in full without interest. If such a recipient repays an overpayment in full within 30 days after the date of the notice, there will be no interest charge. If such a recipient cannot repay an overpayment in full within 30 days after the date of the notice, interest shall be charged. If repayment in full cannot be made within 30 days, such a recipient shall make repayment arrangements subject to IPERS' approval within 30 days of the written notice and request for repayment.

If the overpayment recipient cannot be located to receive notice of the overpayment at the recipient's last-known address, IPERS shall, after trying to locate the person, consider the recipient to have waived entitlement to the quarters covered by the refund.

11.7(4) *Overpayment made to a person who violates a bona fide severance period.* If a recipient takes a refund and does not complete the required period of severance, the recipient shall receive a written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and the opportunity to repay the overpayment in full without interest. The recipient shall have 30 days after the date of notice to repay the full amount of the refund without interest. If the repayment is not made within 30 days after the date of notice, the person shall receive no credit for the period of employment covered by the refund and shall be required to buy back the refund at its actuarial cost if the member later decides that the member wants service credit for any portion of the period of employment covered by the refund.

11.7(5) *Interest charges.*

a. Overpayment not fraudulent. If the overpayment of benefits, other than an overpayment that results from a violation described in subrule 11.7(4), was not the result of wrongdoing, negligence, misrepresentation, or omission of the recipient, the recipient is liable to pay interest charges at the rate of 5 percent, or the rate IPERS determines, on the outstanding balance, beginning 30 days after the date of notice of the overpayment(s) is provided by IPERS.

b. Overpayments as the result of fraud. If the overpayment of benefits, other than an overpayment that results from a violation described in subrule 11.7(4), was the result of wrongdoing, negligence, misrepresentation, or omission of the recipient, the recipient is liable to pay interest charges at the rate of 5 percent on the outstanding balance, beginning on the date of the overpayment(s).

c. Overpayments that result in a judgment. In addition to other remedies, IPERS may file a civil action to recover overpayments, and the interest rate may be set by the court.

11.7(6) *Recovery of overpayment from a deceased recipient.* If a recipient dies prior to the full repayment of an erroneous overpayment of benefits, IPERS shall be entitled to apply to the estate of the deceased to recover the remaining balance.

11.7(7) *Offsets against amounts payable.* IPERS may, in addition to other remedies and after notice to the recipient, request an offset against amounts owing to the recipient by the state according to the offset procedures pursuant to Iowa Code sections 8A.504 and 421.17.

11.7(8) *Rights of appeal.* A recipient who is notified of an overpayment and required to make repayments under this rule may appeal IPERS' determination in writing to the chief executive officer.

The written request must explain the basis of the appeal and must be received by IPERS' office within 30 days of overpayment notice pursuant to 495—Chapter 26.

11.7(9) Release of overpayment. IPERS may release a recipient from liability to repay an overpayment, in whole or in part, if IPERS determines that the receipt of overpayment is not the fault of the recipient, and that it would be contrary to equity and good conscience to collect the overpayment. No release of an individual recipient's obligation to repay an overpayment shall stand as precedent for release of another recipient's obligation to repay an overpayment.

[ARC 8601B, IAB 3/10/10, effective 4/14/10]

These rules are intended to implement Iowa Code sections 97B.4, 97B.9A, 97B.15, 97B.25, 97B.38, 97B.40, 97B.45, 97B.47, 97B.48, 97B.48A, 97B.49A to 97B.49I, 97B.50, 97B.51, 97B.52, 97B.52A, 97B.53, and 97B.53B.

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CHAPTER 12
CALCULATION OF MONTHLY RETIREMENT BENEFITS
[Prior to 11/24/04, see 581—Ch 21]

495—12.1(97B) General.

12.1(1) *Formula benefit versus money purchase benefit.* If a member has four or more complete years of service credit in IPERS, a monthly payment allowance will be paid in accordance with the formulas set forth in Iowa Code sections 97B.49A through 97B.49I, the applicable paragraphs of this chapter, and the option the member elects pursuant to Iowa Code section 97B.51(1). IPERS shall determine on the applicable forms which designated fractions of a member's monthly retirement allowance payable to contingent annuitants shall be provided as options under Iowa Code section 97B.51(1). Any option elected by a member under Iowa Code section 97B.51(1) must comply with the requirements of the Internal Revenue Code that apply to governmental pension plans, including but not limited to Internal Revenue Code Section 401(a)(9) and federal laws governing the tax treatment of distributions from a tax-qualified retirement plan to same gender spouses and same gender former spouses. If a member has less than four complete years of service credit, the benefit receivable will be computed on a money purchase basis, with reference to annuity tables used by IPERS in accordance with the member's age and option choice.

12.1(2) *Reduction for early retirement.*

a. Effective July 1, 1988, through December 31, 2000, a member's benefit formula will be reduced by .25 percent for each month the member's retirement precedes the normal retirement date, as defined in Iowa Code section 97B.45 excluding section 97B.45(4). The following are situations in which a member is considered to be taking early retirement:

- (1) If a member has not attained the age of 65 in the member's first month of entitlement and has less than 20 years of service; or
- (2) If a member has not attained the age of 62 in the month of the member's retirement and has 20 years of service.

b. Effective July 1, 1997, a member shall be eligible to receive monthly retirement benefits with no age reduction effective the first of the month in which the member's age on the last birthday and the member's years of service equal or exceed 88, provided that the member is at least the age of 55.

c. Effective July 1, 1991, a member qualifying for early retirement due to disability under Iowa Code section 97B.50 shall not be subject to a reduction in benefits due to age.

d. If a member retires with at least 20 years of service but has not attained the age of 62, the age reduction shall be calculated by deducting .25 percent per month for each month that the first month of entitlement precedes the month in which the member attains the age of 62. If a member retires with less than 20 years of service, the age reduction shall be calculated by deducting .25 percent per month for each month that the first month of entitlement precedes the month in which the member attains the age of 65.

e. Effective January 1, 2001, the age reduction shall be calculated by deducting .25 percent per month for each month that the first month of entitlement precedes the earliest possible normal retirement date for that member based on the age and years of service at the member's actual retirement.

f. For the portion of the member's retirement allowance based on service through June 30, 2012, the early retirement reduction shall be calculated as provided in paragraphs 12.1(2)"a" through "e." For the portion of the retirement allowance based on years of service beginning July 1, 2012, and later, the member's early retirement reduction shall be one-half of one percent for each month that the early retirement precedes the date the member attains age 65.

12.1(3) *Early retirement date.* A member's early retirement date shall be the first day of the month of the fifty-fifth birthday or any following month before the normal retirement date, provided that date is after the member's termination date.

12.1(4) *Members employed before January 1, 1976, and retiring after January 1, 1976.* Members employed before January 1, 1976, and retiring after January 1, 1976, with four or more complete years of membership service shall be eligible to receive the larger of a monthly formula benefit equal to the

member's total covered wages multiplied by one-twelfth of one and fifty-seven hundredths percent, multiplied by the percentage calculated in subrule 12.1(2), if applicable, or a benefit as calculated in subrule 12.1(6).

12.1(5) *Members employed before January 1, 1976, who qualified for prior service credit.* Members employed before January 1, 1976, who qualified for prior service credit shall be eligible to receive a monthly formula benefit of eight-tenths of one percent multiplied by each year of prior service multiplied by the monthly rate of the member's total remuneration during the 12 consecutive months of prior service for which the total remuneration was the highest, disregarding any monthly rate amount in excess of \$250, plus three-tenths of one percent of the monthly rate amount not in excess of \$250 for each year in which accrued liability for benefit payments created by the abolished system is funded.

12.1(6) *Benefit formulas for members retiring on or after July 1, 1994.*

a. For each active member retiring on or after July 1, 1994, with four or more complete years of service, the monthly benefit will be equal to one-twelfth of an amount equal to 60 percent of the three-year average covered wage multiplied by a fraction of years of service.

b. For all active and inactive vested members, the monthly retirement allowance shall be determined on the basis of the formula in effect on the date of the member's retirement. If the member takes early retirement, the benefit shall be adjusted as provided in subrule 12.1(2).

c. Effective July 1, 1996, through June 30, 1998, in addition to the 60 percent multiplier identified above, members who retire with years of service in excess of their "applicable years" shall have the percentage multiplier increased by 1 percent for each year in excess of their "applicable years," not to exceed an increase of 5 percent. For regular members, "applicable years" means 30 years; for protection occupation members, "applicable years" means 25 years; for sheriffs, deputy sheriffs, and airport firefighters, "applicable years" means 22 years.

d. Effective July 1, 1998, sheriffs, deputy sheriffs, and airport firefighters who retire with years of service in excess of their applicable years shall have their percentage multiplier increased by 1.5 percent for each year in excess of their applicable years, not to exceed an increase of 12 percent.

e. Effective July 1, 2000, the "applicable years" and increases in the percentage multiplier for years in excess of the applicable years for protection occupation members shall be determined under Iowa Code section 97B.49B(1), as set forth in paragraph "*f*" below.

f. For special service members covered under Iowa Code section 97B.49B, the applicable percentage and applicable years for members retiring on or after July 1, 2000, shall be determined as follows:

(1) For each member retiring on or after July 1, 2000, and before July 1, 2001, 60 percent plus, if applicable, an additional .25 percent for each additional quarter of eligible service beyond 24 years of service (the "applicable years"), not to exceed 6 additional percentage points;

(2) For each member retiring on or after July 1, 2001, and before July 1, 2002, 60 percent plus, if applicable, .25 percent for each additional quarter of eligible service beyond 23 years of service (the "applicable years"), not to exceed a total of 7 additional percentage points;

(3) For each member retiring on or after July 1, 2002, and before July 1, 2003, 60 percent plus, if applicable, .25 percent for each additional quarter of eligible service beyond 22 years of service (the "applicable years"), not to exceed a total of 8 additional percentage points;

(4) For each member retiring on or after July 1, 2003, 60 percent plus, if applicable, an additional .375 percent for each additional quarter of eligible service beyond 22 years of service (the "applicable years"), not to exceed a total of 12 additional percentage points.

(5) Regular service does not count as "eligible service" in determining a special service member's applicable percentage.

12.1(7) *Average covered wages.*

a. "Three-year average covered wage" means a member's covered calendar year wages averaged for the highest three years of the member's service. However, if a member's final quarter of a year of employment does not occur at the end of a calendar year, IPERS may determine the wages for the third year by computing the final quarter or quarters of wages to complete the year. The computed year wages shall not exceed the maximum covered wage in effect for that calendar year. Furthermore, for

members whose first month of entitlement is January of 1999 or later, the computed year shall not exceed the member's highest actual calendar year of covered wages by more than 3 percent. Effective July 1, 2007, a member's high three-year average wage shall be the greater of (1) the member's high three-year average covered wage based on covered wages reported through June 30, 2007; or (2) the member's high three-year average covered wage after application of the antispiking control as described in paragraph "c" below.

For members whose first month of entitlement is January 1995 or later, a full third year will be created when the final quarter or quarters reported are combined with a computed average quarter to complete the last year. The value of this average quarter will be computed by selecting the highest covered wage year not used in the computation of the three high years and dividing the covered salary by four quarters. This value will be combined with the final quarter or quarters to complete a full calendar year. If the member's final quarter of wages will reduce the three-year average covered wage, it can be dropped from the computation. However, if the covered wages for that quarter are dropped, the service credit for that quarter will be forfeited as well. If the final quarter is the first quarter of a calendar year, those wages must be used in order to give the member a computed year. The three-year average covered wage cannot exceed the highest maximum covered wages in effect during the member's service.

If the three-year average covered wage of a member who retires on or after January 1, 1997, and before January 1, 2002, exceeds the limits set forth in paragraph "b" below, the longer period specified in paragraph "b" shall be substituted for the three-year averaging period described above. No quarters from the longer averaging period described in paragraph "b" shall be combined with the final quarter or quarters to complete the last year.

b. For the persons retiring during the period beginning January 1, 1997, and ending December 31, 2001, the three-year average covered wage shall be computed as follows:

(1) For a member who retires during the calendar year beginning January 1, 1997, and whose three-year average covered wage at the time of retirement exceeds \$48,000, the member's covered wages averaged for the highest four years of the member's service or \$48,000, whichever is greater.

(2) For a member who retires during the calendar year beginning January 1, 1998, and whose three-year average covered wage at the time of retirement exceeds \$52,000, the member's covered wages averaged for the highest five years of the member's service or \$52,000, whichever is greater.

(3) For a member who retires during the calendar year beginning January 1, 1999, and whose three-year average covered wage at the time of retirement exceeds \$55,000, the member's covered wages averaged for the highest six years of the member's service or \$55,000, whichever is greater.

(4) For a member who retires on or after January 1, 2000, but before January 1, 2001, and whose three-year average covered wage at the time of retirement exceeds \$65,000, the member's covered wages averaged for the highest six years of the member's service or \$65,000, whichever is greater. For the calendar year beginning January 1, 2001, the six-year wage averaging trigger shall be increased to \$75,000.

(5) Effective January 1, 2002, the computation of average covered wages shall be as provided in paragraph 12.1(7)"a."

For purposes of paragraph 12.1(7)"b," the highest years of the member's service shall be determined using calendar years and may be determined using one computed year. The computed year shall be calculated in the manner and subject to the restrictions provided in paragraph 12.1(7)"a."

c. Antispiking limit on the growth of a member's high three-year average.

(1) Selection of the control year shall give highest priority to calendar years of wages in which there are four quarters of service credit for wages on file not used in the high three-year average wage calculation. For example, if the member receives \$20,000 of wages for a calendar year with four quarters of service credit for wages, and the member also has received \$30,000 of wages for a calendar year with three quarters of service credit for wages, the control year selection process shall give preference to the calendar year with \$20,000 of reported wages.

(2) If there is a calendar year of covered wages outside the high three-year average wage calculation that has four quarters, but the covered wages for that year are less than the covered wages for the fourth highest calendar year of covered wages, and that fourth highest calendar year of covered wages does not

have four quarters of service credit for wages, the control year will be the lowest of the high three calendar years of wages with service credits for wages in all four quarters being used in the high three-year average wage calculation.

(3) “Service credit for wages” means service credit recorded for:

1. Quarters in which the member receives covered wages from covered employment.
2. Quarters in which the member is credited with covered wages due to a military leave.
3. Quarters in which the member would have had covered wages but for the application of the IRS covered wage limitations.
4. Quarters in which an employee of a nine-month institution receives service credit for a qualifying leave of absence under 495—subrule 7.1(2).
5. Quarters in which a legislator, legislative employee, or elected official receives service credit for employment.

(4) If none of the calendar years of wages that fall outside of the high three-year average wage calculation have service credit for wages reported in all four quarters, the control year will then be the lowest of the high three calendar years of wages with service credit for wages in all four quarters being used in the high three-year average wage calculation.

(5) If none of the wage years used in the high three-year average wage calculation have service credits for wages reported in all four quarters, the control year will then revert to the highest calendar year of wages not included in the high three-year average wage calculation, regardless of whether there are fewer than four quarters with service credits for wages on file.

(6) For high three-year average wage calculations that utilize the computed year, the control year may be the calendar year from which the “average quarters” used in the computed year are drawn. However, the control year cannot be the computed year, as the computed year will never be a calendar year with service credit for wages in all four quarters.

d. Effective July 1, 2012, a nonvested member’s average covered wage shall be the member’s five-year average covered wage calculated as provided in Iowa Code section 97B.1A(10A)“*a.*”

e. Effective July 1, 2012, for members vested as of June 30, 2012, the member’s average covered wage shall be the greater of the member’s three-year average covered wage calculated as provided under paragraphs 12.1(7)“*a*” through “*c*,” or the member’s five-year average covered wage calculated as provided in Iowa Code section 97B.1A(10A)“*a.*”

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 0017C, IAB 2/22/12, effective 3/28/12]

495—12.2(97B) Initial benefit determination.

12.2(1) The initial monthly benefit for the retired member will be calculated utilizing the wages that have been reported as of the member’s retirement and subject to the requirements of subrule 12.1(7). When the final quarter(s) of wages is reported for the retired member, a recalculation of benefits will be performed by IPERS to redetermine the member’s benefit amount. In cases where the recalculation determines that the benefit will be changed, the adjustment in benefits will be made retroactive to the first month of entitlement. The wages for the “computed year” shall not exceed the highest covered wage ceiling in effect during the member’s period of employment.

12.2(2) In cases where the member’s final quarter’s wages have been reported to IPERS prior to retirement, the original benefit will be calculated utilizing all available wages.

12.2(3) The Option 1 death benefit amount cannot exceed the member’s investment and cannot lower the member’s benefit below the minimum distribution required by federal law.

495—12.3(97B) Minimum benefits. Effective January 1, 1997, those members and beneficiaries of members who retired prior to July 1, 1990, and who upon retirement had years of service equal to or greater than 10, will receive a minimum benefit as follows.

12.3(1) The minimum benefit is \$200 per month for those members with 10 years of service who retired under Option 2. The minimum shall increase by \$10 per year or \$2.50 per each additional quarter of service to a maximum benefit of \$400 per month for members with 30 years of service. No increase

is payable for years in excess of 30. The minimum benefit will be adjusted by a percentage that reflects option choices other than Option 2, and a percentage that reflects any applicable early retirement penalty.

12.3(2) In determining minimum benefits under this rule, IPERS shall use only the years of service the member had at first month of entitlement (FME). Reemployment periods and service purchases completed after FME shall not be used to determine eligibility.

12.3(3) The adjusted minimum benefit amount shall be determined using the option and early retirement adjustment factors set forth below.

a. The option adjustment factor is determined as follows:

Option 1	.94
Option 2	1.00
Option 3	1.00
Option 4 (100%)	.87
Option 4 (50%)	.93
Option 4 (25%)	.97
Option 5	.97

b. The early retirement adjustment factor is determined as follows:

(1) There is no early retirement adjustment if the member's age at first month of entitlement equals or exceeds 65, or if the member's age at first month of entitlement is at least 62 and the member had 30 or more years of service.

(2) The early retirement adjustment for a member having 30 years of service whose first month of entitlement occurred before the member attained age 62 is .25 percent per month for each month the first month of entitlement precedes the member's sixty-second birthday.

(3) The early retirement adjustment for a member having less than 30 years of service whose first month of entitlement occurred before the member attained age 65 is .25 percent per month for each month the first month of entitlement precedes the member's sixty-fifth birthday.

(4) IPERS shall calculate the early retirement adjustment factor to be used in subrule 12.3(4) as follows:

$$100\% - \text{early retirement adjustment percentage} = \text{early retirement adjustment factor}$$

(5) The early retirement adjustment shall not be applied to situations in which the member's retirement was due to a disability that qualifies under Iowa Code section 97B.50 or 97B.50(2).

12.3(4) IPERS shall use the following formula to calculate the adjusted minimum benefit:

$$\text{unadjusted minimum benefit} \times \text{option adjustment factor} \times \text{early retirement adjustment factor} = \text{adjusted minimum benefit}$$

12.3(5) IPERS shall compare the member's current benefit to the adjusted benefit determined as provided in subrules 12.3(3) and 12.3(4). If the member's current benefit is greater than or equal to the adjusted minimum benefit, no change shall be made. Otherwise, the member shall receive the adjusted minimum benefit.

12.3(6) Effective January 1, 1999, the monthly allowance of certain retired members and their beneficiaries, including those whose monthly allowance was increased by the operation of subrules 12.3(3) to 12.3(5), shall be increased. If the member retired from the system before July 1, 1986, the monthly allowance currently being received by the member or the member's beneficiary shall be increased by 15 percent. If the member retired from the system on or after July 1, 1986, and before July 1, 1990, the monthly allowance currently being received by the member or the member's beneficiary shall be increased by 7 percent.

495—12.4(97B) Hybrid formula for members with more than one type of service credit.

12.4(1) Eligibility. Effective July 1, 1996, members having both regular and special service (as defined in Iowa Code section 97B.1A(22)) shall receive the greater of the benefit amount calculated under this subrule or the benefit amount calculated under the applicable nonhybrid benefit formula.

a. Members who are vested by service as defined in Iowa Code section 97B.1A(25) “d” may utilize the hybrid formula.

b. The following classes of members are not eligible for the hybrid formula:

- (1) Members who have only regular service credit.
- (2) Members who have 22 years of special service credit.
- (3) Members who have 30 years of regular service.
- (4) Members who are not vested by service as defined in Iowa Code section 97B.1A(25) “d.”

12.4(2) Assumptions. IPERS shall utilize the following assumptions in calculating benefits under this rule.

a. The member’s average covered wage shall be determined in the same manner as it is determined for the nonhybrid formula.

b. Increases in the benefit formula under this rule shall be determined as provided under Iowa Code section 97B.49D. The percentage multiplier shall only be increased for total years of service over 30.

c. Years of service shall be utilized as follows:

(1) Quarters which have two or more occupation class codes shall be credited as the class that has the highest reported wage for said quarter. A member shall not receive more than one quarter of credit for any calendar quarter, even though more than one type of service credit is recorded for that quarter.

(2) Quarters shall not be treated as special service quarters unless the applicable employer and employee contributions have been made.

12.4(3) Years of service fraction not to exceed one.

a. In no event shall a member’s years of service fraction under the hybrid formula exceed, in the aggregate, one.

b. If the years of service fraction does, in the aggregate, exceed one, the member’s quarters of service credit shall be reduced until the member’s years of service fraction equals, in the aggregate, one.

c. Service credit shall first be subtracted from the member’s regular service credit and, if necessary, shall next be subtracted from the member’s special service credit.

12.4(4) Age reduction. The portion of the member’s benefit calculated under this rule that is based on the member’s regular service shall be subject to a reduction for early retirement. In calculating the age reduction to be applied to the portion of the member’s benefit based on the member’s regular service, the system shall use all quarters of service credit, including both regular and special service quarters.

12.4(5) Calculations. A member’s benefit under the hybrid formula shall be the sum of the following:

a. The applicable percentage multiplier divided by 22 times the years of special service credit times the member’s high three-year average covered wage, plus

b. The applicable percentage multiplier divided by 30 times the years of regular service credit (if any) times the member’s high three-year average covered wage minus the applicable wage reduction (if any).

If the sum of the percentages obtained exceeds the applicable percentage multiplier for that member, the percentage obtained above for each class of service shall be subject to reduction so that the total shall not exceed the member’s applicable percentage multiplier in the order specified in paragraph 12.4(3) “c” of this subrule.

[ARC 0017C, IAB 2/22/12, effective 3/28/12]

495—12.5(97B) Money purchase benefits.

12.5(1) For each member who is vested prior to July 1, 2012, and is retiring prior to July 1, 2012, with less than four complete years of service, a monthly annuity shall be determined by applying the total reserve as of the effective retirement date (plus any retirement dividends standing to the member’s

credit on December 31, 1966) to the annuity tables in use by the system according to the member's age (or member's and contingent annuitant's ages, if applicable). If the member's retirement occurs before January 1, 1995, IPERS' revised 6.5 percent tables shall be used. If the member's retirement occurs after December 31, 1994, IPERS' 6.75 percent tables shall be used.

12.5(2) For each vested member for whom the present value of future benefits under Option 2 is less than the member reserve as of the effective retirement date, a monthly annuity shall be determined by applying the member reserve to the annuity tables in use by the system according to the member's age (or member's and contingent annuitant's ages, if applicable). If the member's retirement occurs before January 1, 1995, IPERS' revised 6.5 percent tables shall be used. If the member's retirement occurs after December 31, 1994, IPERS' 6.75 percent tables shall be used.

12.5(3) For calculations under subrule 12.5(1), the term "total reserve" means the total of the member's investment and the employer's investment as of the effective retirement date, plus any retirement dividends standing to the member's credit as of December 31, 1966. For calculations under subrule 12.5(2), the term "member reserve" means the member's total investment, excluding all other amounts standing to the member's credit.

12.5(4) For calculations under subrule 12.5(1), Options 2, 3, 4, 5 and 6 shall be calculated by dividing the member's total reserve by the applicable Option 2, 3, 4, 5 or 6 annuity factor taken from the system's tables to determine the monthly amount. For calculations under subrule 12.5(2), Options 2, 3, 4, 5 and 6 shall be calculated by dividing the member reserve by the applicable Option 2, 3, 4, 5 or 6 annuity factor taken from the system's tables to determine the monthly amount.

12.5(5) For Option 1, the cost per \$1,000 of death benefit shall be determined according to the system's tables. That cost shall be subtracted from the Option 3 monthly amount to determine the Option 1 monthly benefit amount. The Option 1 death benefit amount shall be reduced as necessary so that the Option 1 monthly benefit amount is not less than one-half of the Option 2 monthly benefit amount.

12.5(6) If the member has prior service (service prior to July 4, 1953), the Option 2 benefit amount calculated under subrules 12.5(1) and 12.5(2) shall be calculated by determining the amount of the member's Option 2 benefit based on the member's prior service and the applicable plan formula, plus the amount of the member's Option 2 benefit based on the member's membership service as determined under this rule. The Option 2 benefit amount based on prior service shall be adjusted for early retirement.

12.5(7) For members retiring after June 30, 2012, the money purchase benefit calculated pursuant to this rule shall be provided to members who are not vested by service as defined in Iowa Code section 97B.1A(25) "d."

[ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 0662C, IAB 4/3/13, effective 5/8/13]

495—12.6(97B) Recalculation for a member aged 70. A member remaining in covered employment after attaining the age of 70 years may receive a retirement allowance without terminating the covered employment. A member who is in covered employment, attains the age of 70 and begins receiving a retirement allowance must terminate all covered employment before the member's retirement allowance can be recalculated to take into account service after the member's original FME. The termination of employment must be a true severance lasting at least 30 days. The formula to be used in recalculating such a member's retirement allowance depends on the date of the member's FME and the member's termination date, as follows:

If the member is receiving a retirement allowance with an FME prior to July 1, 2000, and terminates covered employment on or after January 1, 2000, the member's retirement formula for recalculation purposes shall be the formula in effect at the time of the member's termination from covered employment or, if later, the date the member applies for a recalculation.

In all other cases, the recalculation for a member aged 70 who retires while actively employed shall use the retirement formula in effect at the time of the member's FME.

Payments under this rule shall begin no earlier than the month following the month of termination, upon IPERS' receipt of a member's application for recalculation.

A member receiving a recalculation under this rule after June 30, 2012, will have the member's average covered wage calculated as follows. IPERS will calculate the average high three covered wage

as of June 30, 2012. IPERS will next calculate the average high five covered wage at the time of the member's termination from covered employment or, if later, the date the member applies for a recalculation. IPERS will determine the benefit amount based on the calculation that produces the greatest benefit to the member.

[ARC 0662C, IAB 4/3/13, effective 5/8/13]

495—12.7(97B) Level payment choice for special service members. A level payment choice is created effective July 1, 2002. IPERS shall implement the level payment choice by preparing factors to convert nonhybrid IPERS Options 1, 2, 3, 4, and 5 to the level payment choice. The new benefit feature applies solely to special service members, and any reference to members in this rule shall only apply to special service members.

12.7(1) Conversion rights window. A special service member who qualifies for a July 2002 or later first month of entitlement (FME) may elect to retire under the regular IPERS Option 1, 2, 3, 4 or 5, and later have the member's option converted to the level payment choice. Retroactive adjustments in monthly amounts and death benefits, without interest, shall be provided.

In order to qualify for the conversion and retroactive payments, the member must request the level payment choice in writing no later than six months after the member's first monthly payment. If the member is married, the member's spouse must also consent to the requested change. Election of conversion to the level payment choice shall be irrevocable upon receipt of the first payment under the level payment choice.

A member who has retired under Iowa Code section 97B.49D or under IPERS Option 6 on or after July 1, 2002, and who wishes to receive benefits under this rule may revoke the member's initial election and choose IPERS Option 1, 2, 3, 4, or 5 to be paid as a level payment choice. The conversion to the level payment choice under this subrule is mandatory and irrevocable.

The conversion rights granted in this subrule shall not apply to members whose FME is January 2003 and later. Those members must select the level payment choice at the time they submit an IPERS retirement application.

12.7(2) Member's social security retirement amount. Calculations of a member's level payment choice shall be based on the member's social security retirement amount at age 62 as verified by Social Security Administration statements provided by the member. No adjustments shall be made if subsequent social security statements indicate an increase in the age 62 social security retirement amount. Verification of the social security benefits shall not precede the member's first month of entitlement by more than 12 months.

12.7(3) Death benefit assumptions. In preparing level payment choice factors, IPERS shall assume:

a. For IPERS Options 1 and 2, death benefits under those options shall not be reduced as a result of a member's attaining the age of 62 and having the member's monthly allowance reduced under this rule.

b. For IPERS Options 4 and 5, IPERS shall assume that the contingent annuitant's or beneficiary's monthly payments and death benefits, if any, prior to the date the member attains, or would have attained, age 62 shall be based on the amount that was payable to the member for periods before the member attains, or would have attained, age 62. Beginning with the month that the member attains, or would have attained, age 62, a contingent annuitant's or beneficiary's monthly payments and death benefits, except death benefits under IPERS Options 1 and 2, shall be based on the reduced amount that would have been payable to the member in the month after the month that the member attained age 62.

12.7(4) Favorable experience dividends. An eligible member's or beneficiary's favorable experience dividend, if any, shall be based on the member's or beneficiary's level payment choice monthly amount as of the preceding December 31.

12.7(5) Prohibitions. The following special service members shall be prohibited from receiving benefits under this rule:

- a.* Those who retire under Iowa Code section 97B.49D.
- b.* Those who retire under Option 6.

c. Those who request a level payment amount that reflects less than a full offset for the social security retirement amount at age 62.

d. Those reemployed in covered employment and subsequently retiring, for the period of reemployment. A member who has elected the level payment choice shall have retirement benefits calculated solely for the period of reemployment, except for vesting credit.

12.7(6) Limit on reductions. For a member who has substantial noncovered employment, the application of the level payment choice factors shall not reduce the monthly amount payable to a member at age 62 to less than 50 percent of the monthly amount that would have been payable under IPERS Option 2. Accordingly, payments before age 62 to such members shall be reduced in the same manner, with the corresponding adjustments made to death benefits.

12.7(7) Commencement of level payment option reduction. The monthly benefit of a member who selects the level payment option shall be reduced beginning with the month after the member reaches age 62.

[ARC 0017C, IAB 2/22/12, effective 3/28/12]

495—12.8(97B) Reemployment of retired members.

12.8(1) Effective July 1, 1998, the monthly benefit payments for a member under the age of 65 who has a bona fide retirement and is then reemployed in covered employment shall be reduced by 50 cents for each dollar the member earns in excess of the annual limit. Effective July 1, 2002, this reduction is not required until the member earns the amount of remuneration permitted for a calendar year for a person under the age of 65 before a reduction in federal social security retirement benefits is required, or earns \$30,000, whichever is greater. The foregoing reduction shall apply only to IPERS benefits payable for the applicable year that the member has reemployment earnings and after the earnings limit has been reached. Said reductions shall be applied as provided in subrule 12.8(2).

Effective January 1, 1991, this earnings limitation does not apply to covered employment as an elected official. A member aged 65 or older who has completed at least four full calendar months of bona fide retirement and is later reemployed in covered employment shall not be subject to any wage-earning disqualification.

12.8(2) Beginning on or after July 1, 1996, the retirement allowance of a member subject to reduction pursuant to subrule 12.8(1) shall be reduced as follows:

a. A member's monthly retirement allowance in the following calendar year shall be reduced by the excess benefit paid in the preceding year after the excess benefit payment amount has been determined.

b. Employers shall be required to complete IPERS wage reporting forms for reemployed individuals which shall reflect the prior year's wage payments on a month-to-month basis. These reports shall be used by IPERS to determine the amount which must be recovered to offset overpayments in the prior calendar year due to reemployment wages.

c. The member's overpayment shall be collected as follows:

(1) If the overpayment can be repaid by deducting up to 30 percent of each net monthly payment in three installments or less, IPERS shall adjust the member's monthly benefit accordingly. If the adjustment cannot be repaid in three payments, a repayment agreement must be signed by the member and IPERS; or

(2) A member may elect to make repayments of the overpayment amounts out of pocket in lieu of having the member's monthly benefit reduced. An out-of-pocket repayment may be made in one check or in installments. However, an election to make repayment in installments must be accompanied by a repayment agreement signed by the member and IPERS.

(3) If a member dies and the full amount of overpayment determined under this subrule has not been repaid, the remaining amounts shall be deducted from the payments to be made, if any, to the member's designated beneficiary or contingent annuitant. If the member has selected an option under which there are no remaining amounts to be paid, or the remaining amounts are insufficient, the unrecovered amounts shall be a charge on the member's estate.

(4) A member may elect in writing to have the member's monthly retirement allowance suspended in the month in which the member's remuneration exceeds the amount of remuneration permitted under this subrule in lieu of receiving a reduced retirement allowance under subparagraph (1). In order to become effective, the member's written election must be delivered to IPERS in person, by regular mail, E-mail, facsimile or by private carrier. Oral elections shall not be accepted. The member's election to suspend benefit payments in the month when the member's remuneration exceeds the amount of reimbursement permitted under this subrule shall remain in effect for all subsequent calendar years until revoked by the member in writing. If the member's written election is not received in time to avoid overpayment, the overpayment must be recovered, to the extent possible, from monthly amounts beginning in January of the next calendar year or under one of the alternate arrangements permitted under this rule. Effective July 1, 2007, remuneration shall include those amounts as described in 495—subrule 6.3(13).

12.8(3) A member who is reemployed in covered employment after retirement may, after again retiring from employment, request a recomputation of benefits. The member's retirement benefit shall be increased if possible by the addition of a second annuity, which is based on years of reemployment service, reemployment covered wages and the benefit formula in place at the time of the recomputation. A maximum of 30 years of service is creditable to an individual retired member. If a member's combined years of service exceed 30, a member's initial annuity may be reduced by a fraction of the years in excess of 30 divided by 30. The second retirement benefit will be treated as a separate annuity by IPERS. Any contributions that cannot be used in the recomputation of benefits shall be refunded to the employee and the employer.

Effective July 1, 1998, a member who is reemployed in covered employment after retirement may, after again terminating employment for at least one full calendar month, elect to receive a refund of the employee and employer contributions made during the period of reemployment in lieu of a second annuity. If a member requests a refund in lieu of a second annuity, the related service credit shall be forfeited.

Effective July 1, 2007, employer contributions described in 495—subrule 6.3(13) shall constitute "remuneration" for purposes of applying the reemployment earnings limit and determining reductions in the member's monthly benefits but shall not be considered covered wages for IPERS benefits calculations.

12.8(4) In recomputing a retired member's monthly benefit, IPERS shall use the following assumptions.

- a. The member cannot change the option or beneficiary with respect to the reemployment period.
- b. If the member would only qualify for a money purchase benefit under rule 495—12.5(97B) based solely on the period of reemployment, then the money purchase formula shall be used to compute the additional benefit amount due to the reemployment.
- c. If the member would qualify for a non-money purchase retirement allowance based solely on the period of reemployment, the benefit formula in effect as of the first month of entitlement (FME) for the reemployment period shall be used. If the FME is July 1998 or later, and the member has more than 30 years of service, including both original and reemployment service, the percentage multiplier for the reemployment period only will be at the applicable percentage (up to 65 percent) for the total years of service.
- d. If a period of reemployment would increase the monthly benefit a member is entitled to receive, the member may elect between the increase and a refund of the employee and employer contributions without regard to reemployment FME.
- e. If a member previously elected IPERS Option 1, is eligible for an increase in the Option 1 monthly benefits, and elects to receive the increase in the member's monthly benefits, the member's Option 1 death benefit shall also be increased if the investment is at least \$1,000. The maximum amount of the increase shall be equal to the member's investment (reemployment contributions and interest). In determining the increase in Option 1 death benefits, IPERS shall round up to the nearest \$1,000. For example, if a member's investment for a period of reemployment is \$2,900, the maximum death benefit attributable to the reemployment shall be \$3,000 (\$2,900 rounded up to the nearest \$1,000). In

the example above, the member may choose a death benefit increase of \$1,000, or \$2,000, or \$3,000, but must choose at least the \$1,000 increase. Notwithstanding the foregoing, if the member's investment for the period of reemployment is less than \$1,000, the benefit formula for a member who originally elected new IPERS Option 1 shall be calculated under IPERS Option 3.

f. A retired reemployed member whose reemployment FME precedes July 1998 shall not be eligible to receive the employer contributions made available to retired reemployed members under Iowa Code section 97B.48A(4) effective July 1, 1998.

g. A retired reemployed member who requests a return of the employee and employer contributions made during a period of reemployment cannot repay the distribution and have the service credit for the period of reemployment restored.

h. If a retired reemployed member selected IPERS Option 5 at retirement, and after the period of reemployment requests an increase in the member's monthly allowance, at death all remaining guaranteed payments with respect to both periods of employment shall be paid in a commuted lump sum.

i. If a retired reemployed member selected IPERS Option 2 (or old IPERS Option 1) at retirement, and after the period of reemployment requests an increase in the member's monthly allowance, at death the member's monthly payments following the increase shall be prorated between the member's two annuities to determine the amount of the member's remaining accumulated contributions that may be paid as a death benefit.

j. A retired reemployed member who has attained the age of 70 may take an actuarial equivalent (AE) payment. However, such a member must terminate covered employment for at least 30 days before taking an additional AE payment.

12.8(5) Mandatory distribution of active wages. If a retired reemployed member whose annual benefit would be increased by less than \$600 does not request a second annuity or a lump sum payment of reemployment accruals by the end of the fourth quarter after the last quarter in which the member had covered wages, IPERS shall proceed to pay the member the applicable lump sum amount. The member shall have 60 days after the postmark date of the mandatory payment to return the payment and restore the member's account.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 0017C, IAB 2/22/12, effective 3/28/12]

495—12.9(97B) Actuarial equivalent (AE) payments.

12.9(1) If a member aged 55 or older requests an estimate of benefits which results in a monthly benefit amount under Option 2 of less than \$50, the member shall receive, under Iowa Code section 97B.48(1), a lump sum actuarial equivalent (AE) payment in lieu of a monthly benefit. Once the AE payment has been paid to the member, the member shall not be entitled to any further benefits based on the contributions included in the AE payment and the employment period represented thereby. If the member later returns to covered employment, any future benefits the member accrues shall be based solely on the new employment period. If an estimate of benefits based on the new employment period again results in any one of the options having a monthly benefit amount of less than \$50, the member may again elect to receive an AE payment.

12.9(2) If a member, upon attaining the age of 70 or later, requests a retirement allowance without terminating employment and the member's monthly benefit amount under Option 2 is less than \$50, the member shall receive an AE payment based on the member's employment up to, but not including, the quarter in which the application is filed. When the member subsequently terminates covered employment, any benefits due to the member will be based only on the period of employment not used in computing the AE paid when the member first applied for a retirement allowance. If an estimate of benefits based on the later period of employment again results in a monthly benefit amount under Option 2 of less than \$50, the member shall receive another AE payment. However, a member who elects to receive an AE payment upon or after attaining age 70 without terminating employment may not elect to receive additional AE payments unless the member terminates all covered employment for at least one full calendar month.

12.9(3) An AE payment under this rule shall be equal to the sum of the member's and employer's accumulated contributions and the retirement dividends standing to the member's credit before December 31, 1966.

495—12.10(97B) Conforming rules for lump-sum payments. Effective January 1, 2007, IPERS may, notwithstanding certain provisions of Iowa Code section 97B.53B enacted in order to comply with prior rollover provisions of the Internal Revenue Code, utilize forms and procedures affording payees of lump-sum distributions with broader rollover rights as permitted under the applicable roll-over provisions of the Internal Revenue Code as amended subsequent to the enactment of Iowa Code section 97B.53B.

These rules are intended to implement Iowa Code sections 97B.1A, 97B.1A(24), 97B.15, 97B.25, 97B.45, 97B.47 to 97B.48A, 97B.49A to 97B.49I, 97B.51, and 97B.53B.

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CHAPTER 13
DISABILITY FOR REGULAR AND SPECIAL SERVICE MEMBERS

[Prior to 11/24/04, see 581—Ch 21]

495—13.1(97B) Disability for persons retiring under Iowa Code section 97B.50(2).

13.1(1) For IPERS regular class members retiring because of a disability:

a. The member must indicate on the application for retirement that the retirement is due to an illness, injury or similar condition.

b. The member must be awarded federal social security benefits due to a disability which existed at the time the application for retirement was filed.

c. Effective July 1, 1990, the member may also qualify for the IPERS disability provision by being awarded, and commencing to receive, disability benefits through the federal Railroad Retirement Act, 45 U.S.C. Section 231 et seq., due to a disability which existed at the time of retirement.

d. The period for which up to 36 months of retroactive payments under Iowa Code section 97B.50(2) shall be paid is for up to 36 months preceding the month in which such completed application for IPERS disability is received by IPERS. In no event shall retroactive disability benefits payments under Iowa Code section 97B.50(2) precede the month the member actually receives the member's first social security or railroad retirement disability payment. The member shall provide IPERS with a copy of the Social Security Administration award letter showing dates of eligibility.

e. Continued qualification monitoring. For a member retiring due to a disability on or after January 1, 2009, in order to continue qualification for disability benefits, the member shall provide IPERS with proof of continuing eligibility for federal social security disability benefits or railroad retirement disability benefits by June 30 of each calendar year. IPERS may also require complete copies of the member's state and federal income tax returns, including all supporting schedules, by June 30 of each calendar year. IPERS may suspend the benefits of any such member if these records are not timely provided.

13.1(2) If a member returns to covered employment after achieving a bona fide retirement, the benefits being provided to the member under Iowa Code section 97B.50(2) "a" or "b" shall be suspended or reduced as follows. If the member has not attained the age of 55 upon reemployment, benefit payments shall be suspended in their entirety until the member subsequently terminates employment, applies for, and is approved to receive benefits under the provisions of Iowa Code chapter 97B. If the member has attained the age of 55 or older upon reemployment, the member shall continue to receive monthly benefits adjusted as follows. Monthly benefits shall be calculated under the same benefit option that was first selected, based on the member's age, years of service, and the applicable reductions for early retirement as of the month that the member returns to covered employment. The member's benefit shall also be subject to the applicable provisions of Iowa Code section 97B.48A pertaining to reemployed retired members.

13.1(3) Upon terminating a reemployment that resulted in the suspension of all or a portion of the member's disability retirement allowance, the member's benefits shall be recomputed under Iowa Code section 97B.48A and rule 495—12.8(97B). To requalify for a monthly retirement allowance under Iowa Code section 97B.50(2), the member must furnish a new or updated Social Security Administration disability award letter, or other acceptable documentation from the Social Security Administration, indicating that the member is currently eligible for social security disability benefits.

13.1(4) If a member whose IPERS disability benefits were suspended because of the member's return to covered employment provides proof acceptable to IPERS that the member remains eligible for federal social security disability benefits or railroad retirement disability benefits, IPERS shall reinstate the member's disability benefits, subject to the member's continued compliance with paragraph 13.1(1) "e."

495—13.2(97B) Disability claim process for special service members. Except as otherwise indicated, this rule shall apply only to disability claims initiated under Iowa Code section 97B.50A. Except as otherwise indicated, disability claims under Iowa Code section 97B.50(2) shall be administered under rule 495—13.1(97B).

13.2(1) *Initiation of disability claim.* The disability claim process shall originate as an application to the system by the member. The application shall be forwarded to the system's designated retirement benefits officer. An application shall be sent upon request to members who qualify pursuant to Iowa Code section 97B.50A(13). The application consists of the following sections which must be completed and returned to the system's designated retirement benefits officer:

1. General applicant information.
2. Applicant's statement.
3. Employer's statement.
4. Member's assigned duties.
5. Disability/injury reports.
6. Medical information release.

13.2(2) *Preliminary processing.* Completed forms shall be returned to the disability retirement benefits officer. If the forms are not complete, they will be returned for completion. The application package shall contain copies of all relevant medical records and the names, addresses, and telephone numbers of all relevant physicians. If medical records are not included, the designated retirement benefits officer shall have the authority to contact the listed physicians for copies of the files on the individual and shall request that any applicable files be sent to the medical board. In addition, IPERS may request workers' compensation records, social security records and such other official records as are deemed necessary. The application, including copies of the medical information, shall be forwarded to the medical board for review. All medical records that will be part of a member's permanent file shall be kept in locked locations separate from the member's other retirement records.

13.2(3) *Scheduling of appointments.* Upon receipt and forwarding of the application and sufficient medical records to the medical board, the disability retirement benefits officer shall establish an appointment for the applicant to be seen by the medical board in Iowa City. The member shall be notified by telephone and in writing of the appointment, and shall be given general instructions about where to go for the examinations. The appointment for the examinations shall be no later than 60 days after the completed application, including sufficient medical records, is provided. All examinations must be scheduled and completed on the same date. The member shall also be notified about the procedures to follow for reimbursement of travel expenses and lodging. Fees for physical examinations and medical records costs shall be paid directly by IPERS pursuant to its contractual arrangements with the medical providers required to implement Iowa Code section 97B.50A.

13.2(4) *Medical board examinations.* The medical board, consisting of three physicians from the University of Iowa occupational medicine clinic and other departments as required, shall examine the member and perform the relevant tests and examinations.

The medical board shall submit a letter of recommendation to the system, based on its findings and the job duties supplied in the member's application, whether or not the member is mentally or physically incapacitated from the further performance of the member's duties and whether or not the incapacity is likely to be permanent. "Permanent" means that the mental or physical incapacity is reasonably expected to last more than one year. The medical board's letter of recommendation shall include a recommended schedule for reexaminations to determine the continued existence of the disability in question.

IPERS shall not be liable for any diagnostic testing procedures performed in accordance with Iowa Code section 97B.50A and this rule which are alleged to have resulted in injury to the members being examined.

The medical board shall furnish its determination, test results, and supporting notes to the system no later than ten working days after the date of the examination. The medical board may use electronic signatures in fulfilling its reporting obligations under this rule.

The medical board shall not be required to have regular meetings, but shall be required to meet with IPERS' representatives at reasonable intervals to discuss the implementation of the program and performance review.

13.2(5) *Member and employer comments.* Upon receipt by the system, the medical board's determination regarding the existence or nonexistence of a permanent disability shall be distributed to the member and to the employer for review. The member and the employer may forward to the

system written statements pertaining to the medical board's findings within ten days of transmittal. If relevant medical information not considered in materials previously forwarded to the medical board is contained within such written statements, the system shall submit such information to the medical board for review and comment.

13.2(6) *Fast-track review.* IPERS' disability retirement benefits officer may refer any case to IPERS' chief benefits officer (CBO) for fast-track review. The CBO or the CBO's designee may, based upon a review of the member's application and medical records, determine that the medical board be permitted to make its recommendations based solely upon a review of the application and medical records, without requiring the member to submit to additional medical examinations by, or coordinated through, the medical board.

13.2(7) *Initial administrative determination.* The medical board's letter of recommendation, test results, and supporting notes, and the member's file shall be forwarded to IPERS. Except as otherwise requested by IPERS, the medical board shall forward hospital discharge summary reports rather than the entire set of hospital records. The complete file shall be reviewed by the system's disability retirement benefits officer, who shall, in consultation with the system's legal counsel, make the initial disability determination. Written notification of the initial disability determination shall be sent to the member and the member's employer within 14 business days after a complete file has been returned to IPERS for the initial disability determination.

13.2(8) *General benefits provisions.* Effective July 1, 2000, if an initial disability determination is favorable, benefits shall begin as of the date of the initial disability determination or, if earlier, the member's last day on the payroll, but no more than six months of retroactive benefits are payable, subject to Iowa Code section 97B.50A(13). "Last day on the payroll" shall include any form of authorized leave time, whether paid or unpaid. If a member receives short-term disability benefits from the employer while awaiting a disability determination hereunder, disability benefits will accrue from the date the member's short-term disability payments are discontinued. If an initial favorable determination is appealed, the member shall continue to receive payments pending the outcome of the appeal.

Any member who is awarded disability benefits under Iowa Code section 97B.50A and this rule shall be eligible to elect any of the benefit options available under Iowa Code section 97B.51. All such options shall be the actuarial equivalent of the lifetime monthly benefit provided in Iowa Code section 97B.50A(2) and (3).

The disability benefits established under this subrule shall be eligible for the favorable experience dividends payable under Iowa Code section 97B.49F(2).

If the award of disability benefits is overturned upon appeal, the member may be required to repay the amount already received or, upon retirement, have payments suspended or reduced until the appropriate amount is recovered.

IPERS shall, at the member's written request, precertify a member's medical eligibility through the procedures set forth in subrules 13.2(3) and 13.2(4), provided that IPERS shall have full discretion to request additional medical information and to redetermine the member's medical eligibility if the member chooses not to apply for disability benefits at the time of the precertification. IPERS shall not pay for the costs of more than one such precertification per 12-month period.

13.2(9) *In-service disability determinations.* Subject to the presumptions contained in Iowa Code section 97B.50A in determining whether a member's mental or physical incapacity arises in the actual performance of duty, "duty" shall mean:

a. For special service members other than firefighters, any action that the member, in the member's capacity as a law enforcement officer:

(1) Is obligated or authorized by rule, regulation, condition of employment or service, or law to perform; or

(2) Performs in the course of controlling or reducing crime or enforcing the criminal law; or

b. For firefighters, any action that the member, in the member's capacity as a firefighter:

(1) Is obligated or authorized by rule, regulation, condition of employment or service, or law to perform; or

(2) Performs while on the scene of an emergency run (including false alarms) or on the way to or from the scene.

c. A presumption shall exist that a special service member contracted a disease while on active duty only if the disease is defined by Iowa Code section 97B.50A(2) “c” as amended by 2010 Iowa Acts, House File 2518, section 31. If a presumption exists, IPERS may, in making its determination as to whether a disability was incurred while the member was on active duty, go forward with evidence to rebut the presumption. IPERS can rebut the presumption when credible evidence exists to the contrary or when the requirements are met in Iowa Code section 97B.50A(2) “c” as amended by 2010 Iowa Acts, House File 2518, section 31. Under no circumstances shall the burden of proof shift from the special service member to IPERS.

13.2(10) Appeal rights. The member or the employer, or both, may appeal IPERS’ initial disability determination. Within 30 days after the notification of IPERS’ initial disability determination was mailed, the member shall submit to IPERS’ CEO or CEO’s designee a notice of appeal in writing setting forth:

- a. The name, address, and social security number of the member or employee number of the employer;
- b. A reference to the decision from which the appeal is being made;
- c. The fact that an appeal from the decision is being made;
- d. The grounds upon which the appeal is based;
- e. Additional medical or other evidence to support the appeal; and
- f. The request that a different decision be made by IPERS.

The system shall conduct an internal review of the initial disability determination, and the CEO or CEO’s designee shall notify in writing the party who filed the appeal of IPERS’ final disability determination with respect to the appeal. The CEO or CEO’s designee may appoint a review committee to make nonbinding recommendations on such appeals. The disability retirement benefits officer, if named to the review committee, shall not vote on any such recommendations, nor shall any members of IPERS’ legal staff participate in any capacity other than a nonvoting capacity. Further appeals shall follow the procedures set forth in 495—Chapter 26.

13.2(11) Notice of abuse of disability benefits. The system has the obligation and full authority to investigate allegations of abuse of disability benefits. The scope of the investigation to be conducted shall be determined by the system, and may include the ordering of a sub rosa investigation of a disability recipient to verify the facts relating to an alleged abuse. A sub rosa investigation shall only be considered upon receipt and evaluation of an acceptable notice of abuse. The notification must be in writing and include:

- a. The informant’s name, address, telephone number, and relationship to the disability recipient; and
- b. A statement pertaining to the circumstances that prompted the notification, such as activities which the informant believes are inconsistent with the alleged disability.
- c. Anonymous calls shall not constitute acceptable notification.

IPERS may employ such investigators and other personnel, in IPERS’ sole discretion, as may be deemed necessary. IPERS may also, in its sole discretion, decline to carry out such investigations if more than five years have elapsed since the date of the disability determination.

13.2(12) Qualification for social security or railroad retirement disability benefits. Upon qualifying for social security or railroad retirement disability benefits, a special service member may contact the system to have the member’s disability benefits calculated under Iowa Code section 97B.50(2). The member and spouse must complete the designated application to stop having benefits calculated under Iowa Code section 97B.50A and to start having benefits calculated under Iowa Code section 97B.50(2). The decision is irrevocable, and must be made within 60 days after the member receives written notification of eligibility for disability benefits from social security or railroad retirement and has commenced receiving such payments.

13.2(13) Reemployment/income monitoring. A member who retires under Iowa Code section 97B.50A and this rule shall be required to supply a copy of a complete set of the member’s state and

federal income tax returns, including all supporting schedules, by June 30 of each calendar year. IPERS may suspend the benefits of any such member if such records are not timely provided.

Only wages and self-employment income shall be counted in determining a member's reemployment comparison amount, as adjusted for health care coverage for the member and member's dependents.

For purposes of calculating the income offsets required under Iowa Code section 97B.50A, IPERS shall convert any lump sum workers' compensation award, disability insurance payments, or similar lump sum awards for the same illnesses or injuries to an actuarial equivalent, as determined by IPERS. [ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10; ARC 0662C, IAB 4/3/13, effective 5/8/13]

These rules are intended to implement Iowa Code sections 97B.50 and 97B.50A.

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CHAPTER 15
DIVIDENDS

[Prior to 11/24/04, see 581—Ch 21]

495—15.1(97B) Dividend payments for beneficiaries of members retiring prior to July 1, 1990, who chose joint and survivor annuity options.

15.1(1) November dividend adjustment. Effective July 1, 2008, in order to determine whether the adjustment to dividend payments is payable under Iowa Code section 97B.49F(1) “b,” an IPERS actuary shall compare the actuarially required contribution rate for the fiscal year of the dividend adjustment to the statutory contribution rate for that same fiscal year and certify the results to IPERS. If the actuarially required contribution rate exceeds the statutory contribution rate for that same fiscal year, the applicable percentage used to calculate dividend adjustments shall be zero.

15.1(2) General. The dividend payable to the beneficiary of a pre-July 1, 1990, retired member who selected a joint and survivor annuity option, except for the year of the member’s death and the next year, is calculated in the same manner as for retired members.

For a member who lives into November of the year in which the member dies, the dividend will be payable to the member’s account.

15.1(3) Dividend for the years in which member’s death occurs. For a member who does not live into November of the year in which the member dies, the dividend payable for the year in which the member dies is calculated the same as it would have been calculated for the deceased retired member. The dividend amount that would have been payable to the deceased retired member is then multiplied by the survivor annuity percentage selected for the contingent annuitant (CA) in the member’s retirement application.

15.1(4) Dividend for the year following the year of the retired member’s death. For a member who does not live into November of the year in which the member dies, the dividend payable in the year following the year of the member’s death is calculated as follows. The sum of the survivor’s monthly benefit payments received for the year in which the member’s death occurs is divided by the number of survivor benefit payments for that year, and that amount is multiplied by 12. That amount plus the member’s survivor’s prior dividend is then multiplied by the dividend rate for the year following the year of the member’s death, which equals the dividend adjustment for the year following the year of the member’s death. This dividend adjustment plus the prior year’s dividend produces the dividend amount for the year following the year of the member’s death.

15.1(5) Examples.

a. Dividend for the year of the member’s death. The following assumptions are made. The member retired in 1989 and selected a joint and 50 percent to survivor annuity. The retired member received a monthly payment of \$1,000, and died in June 2002. The member received \$12,000 in monthly benefits for January through December 2001. The member received a dividend of \$500 in 2001, and the dividend rate is 3 percent for 2002.

2001 total monthly benefits	2001 dividend amount	2002 dividend rate	2002 dividend adjustment	2001 dividend amount	Dividend payable amount	CA%	CA 2002 dividend							
\$12,000.00	+	\$500.00	×	3%	=	\$375.00	+	\$500.00	=	\$875.00	×	50%	=	\$437.50

b. Dividend for the year following the year of the member’s death. The following assumptions are made. The member retired in 1989 and selected a joint and 50 percent to survivor annuity. The retired member received a monthly payment of \$1,000, and died in June 2002. The survivor received \$500 each month for July through December of 2002 for a total of \$3,000. The survivor received a dividend of \$437.50 in 2002, and the dividend rate is 3 percent for 2003.

2002 total monthly benefits for CA	÷	Total of payments for CA 2002	×	Twelve months for 2002	+	2002 dividend amount	×	2003 dividend rate	=	2003 dividend adjustment	+	2002 dividend amount	=	Dividend payable to CA for 2003
\$3,000.00		6 months		12 months		\$437.50		3%		\$193.13		\$437.50		\$630.63

[ARC 7759B, IAB 5/6/09, effective 4/17/09; ARC 7916B, IAB 7/1/09, effective 8/5/09]

495—15.2(97B) Favorable experience dividend (FED) under Iowa Code section 97B.49F(2). For members retiring on and after July 1, 1990, dividends are payable as follows.

15.2(1) Allocation of favorable experience. The system shall, following the first annual actuarial evaluation in which IPERS is found to be fully funded, determine by rule the allocation of the system's favorable actuarial experience, if any, between the reserve account created under Iowa Code section 97B.49F(2) and the remainder of the retirement fund.

Effective July 1, 2006, IPERS shall in no event credit amounts attributable to favorable experience to the FED reserve account, unless IPERS is fully funded and will remain fully funded after such amounts are credited to the FED reserve account. "Fully funded" means that the funded ratio as determined under Iowa Code section 97B.1A(11A) remains at least 100 percent following the allocation of favorable experience to the FED reserve account.

15.2(2) Determination of applicable percentage. The system shall have sole discretion to determine the applicable percentages that will be used in calculating favorable experience dividends payable under this rule, if any, subject to the actuary's certification that the resulting favorable experience dividends meet the requirements of Iowa Code section 97B.49F(2) and this rule.

a. The system's annual applicable percentage target for calculating dividends under Iowa Code section 97B.49F(2) shall be equal to the applicable percentage used in calculating dividends payable to retired members under Iowa Code section 97B.49F(1). Notwithstanding the foregoing, the system may set a greater or lesser applicable percentage for calculating dividends under this rule depending on the funding adequacy of the reserve account. In no event shall the applicable percentage exceed 3 percent.

b. In determining the annual applicable percentage, the system shall consider, but not be limited to, the value of the reserve account, distributions made from the reserve account in previous years, and the likelihood of future credits to and distributions from the reserve account. The system shall make its annual applicable percentage decisions using at least a rolling five-year period.

c. If for any year the system cannot afford an applicable percentage equal to that payable to retired members under Iowa Code section 97B.49F(1), the system may use applicable percentages in succeeding years that are higher than those used in calculating dividends for retired members under Iowa Code section 97B.49F(1) (but not in excess of 3 percent).

d. An applicable percentage in excess of the applicable percentage declared under Iowa Code section 97B.49F(1) made for catch-up purposes shall not reduce the funding of the reserve account below the amount the system's actuary determines is necessary to pay the maximum favorable experience dividend for each of the next five years, based on reasonable actuarial assumptions.

15.2(3) Calculation of FED for individual members and beneficiaries. A member must be retired for one full year to qualify for a favorable experience dividend. In determining whether a member has been retired one full year, the system shall count the member's first month of entitlement as the first month of the one-year period. The month in which the favorable experience dividend is payable shall be included in determining whether a member meets the eligibility requirements.

An eligible member's favorable experience dividend shall be calculated by multiplying the retirement allowance payable to the retired member, beneficiary, or contingent annuitant for the previous December, or such other month as determined by the system, by 12, and then multiplying that amount by the number of complete years the member has been retired or would have been retired if living on the date the dividend is payable, and by the applicable percentage set by the system. The number of complete years the member has been retired shall be determined by rounding down to the nearest whole year.

For otherwise eligible retired reemployed members who chose to suspend their monthly allowance under 495—paragraph 12.8(2) “c,” the suspension shall have no effect on the calculation of FED.

15.2(4) *FED for eligible members and beneficiaries who die before the January distribution date.* If a member or beneficiary receiving monthly payments would have been eligible for a FED distribution in the following January but dies prior to the January distribution date, IPERS will pay a FED to the member’s or beneficiary’s account for the calendar year in which the death occurred. The FED shall be calculated using the monthly payments received in the calendar year the death occurred. A lump sum death benefit shall not constitute a monthly payment for purposes of determining FED eligibility or in making FED calculations.

The FED percentage applied to the monthly payments received in the calendar year of death shall be the most recently declared FED percentage in effect at the time of the FED payment to the member or beneficiary. This subrule shall not be construed to permit a FED distribution to a member where the total monthly benefits received by the member, counting the month of death, is less than 12, even if a period of 12 months has elapsed between the first payment of monthly benefits to the member and the January distribution date.

Notwithstanding the foregoing, if IPERS determines in January of a given year that, based on reasonable actuarial assumptions, there is a reasonable likelihood that a FED will not be declared for the next following January, IPERS may defer paying FED distributions under this subrule until the determination is made. If IPERS subsequently determines that no FED will be declared for a given year, no FED will be payable to a person whose death occurs during the applicable calendar year.

Effective July 1, 2000, a retired member or beneficiary eligible for a FED payment must, in addition to all other applicable requirements, be living on January 1 in order to receive a FED payment otherwise payable in that January.

15.2(5) *Limit on transfers of favorable experience.* Rescinded IAB 11/22/06, effective 12/27/06.

15.2(6) *Determination of sufficiency of FED reserve account.* The system is charged in Iowa Code section 97B.49F(2) “d” with determining whether the reserve account is sufficiently funded to make a distribution. The system shall make this determination in the following manner.

a. The system shall declare the value of the FED reserve account balance as specified in the Allocation of Net Assets Held in Trust in the financial statements for the fiscal year that ended immediately preceding a January FED payment. The value shall include, but is not limited to, investment income and expenses and certain noninvestment income that are properly recorded for the FED reserve balance based on standard accounting rules used to determine a final balance at the conclusion of a fiscal year.

b. The above-declared reserve account balance shall be compared to the total estimated FED payment for the following January as calculated pursuant to rule 495—15.2(97B) utilizing a 1 percent multiplier.

c. The reserve account shall be declared not sufficiently funded when the estimated FED payment as determined in paragraph “b” of this subrule is equal to or greater than the declared reserve account balance as defined in paragraph “a” of this subrule.

15.2(7) *Determination of FED distribution if reserve account is not sufficiently funded.*

a. When the system has determined pursuant to subrule 15.2(6) that the reserve account is not sufficiently funded, the system shall declare a multiplier to be used in the formula pursuant to rule 495—15.2(97B) that is best estimated to approximate a full distribution of the declared reserve account balance as of the preceding June 30 fiscal year end.

b. No investment gains or losses shall change this balance between July 1 and the FED payment in January of the fiscal year in which the remaining balance of the reserve account will be paid by IPERS.

c. Any remaining reserve account balance shall be credited among the membership groups in the net assets held in trust, and the reserve account balance will be zero at the end of the fiscal year in which a FED payment is made pursuant to this subrule.

d. Any funds the system collects from a FED payment to a member or beneficiary because of an erroneous FED payment made by IPERS shall be deposited in the IPERS trust fund.

e. Payments under this subrule will represent a final distribution of the balance of the reserve account as determined in rule 495—15.2(97B) effectively halting any future FED payment, unless and until the reserve account is funded again pursuant to subrule 15.2(1).

f. No claim or administrative appeal will be allowed under this subrule if made more than 30 calendar days following the date on which IPERS made a FED payment to a member or beneficiary based upon the date of the EFT or the date IPERS mailed a state warrant to the member or beneficiary.

g. No payment will occur after January 31 in the year of the FED payment under this subrule for any adjustment to any previous fiscal years' FED payment to a member or beneficiary.

[ARC 0662C, IAB 4/3/13, effective 5/8/13]

These rules are intended to implement Iowa Code sections 97B.1A(11A), 97B.49F and 97B.70.

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CHAPTER 16
DOMESTIC RELATIONS ORDERS AND OTHER ASSIGNMENTS

[Prior to 11/24/04, see 581—Ch 21]

495—16.1(97B) Garnishments and income withholding orders.

16.1(1) For the limited purposes of this rule, the term “member” includes IPERS members, beneficiaries, contingent annuitants and any other third-party payees to whom IPERS is paying a monthly benefit or a lump sum distribution.

16.1(2) A member’s right to any payment from IPERS is not transferable or assignable and is not subject to execution, levy, attachment, garnishment, or other legal process, including bankruptcy or insolvency law, except for the purpose of enforcing child, spousal, or medical support.

16.1(3) Only members receiving payment from IPERS, including monthly benefits and lump sum distributions, may be subject to garnishment, attachment, or execution against funds that are payable. Such garnishment, attachment, or execution is not valid and enforceable for members who have not applied for and have not been approved to receive funds from IPERS.

16.1(4) Upon receipt of an income withholding order issued by the Iowa department of human services or a court, IPERS shall send a copy of the withholding order to the member. If a garnishment has been issued by a court, the party pursuing the garnishment shall send a notice pursuant to Iowa law to the member against whom the garnishment is issued.

16.1(5) IPERS shall continue to withhold a portion of the member’s monthly benefit as specified in the initial withholding order until instructed by the court or the Iowa department of human services issuing the order to amend or cease payment. IPERS shall continue to withhold a portion of the member’s monthly benefit as specified in the garnishment until the garnishment expires or is released.

16.1(6) Funds withheld or garnished are taxable to the member. IPERS may assess a fee of \$2 per payment in accordance with Iowa Code section 252D.18A(2). The fee will be deducted from the gross amount, less federal and state income tax, before a distribution is divided.

16.1(7) A garnishment, attachment or execution may not be levied upon funds which are already the subject of a levy, including a levy placed upon funds by the United States Internal Revenue Service, unless the requirements of IRC Section 6334(a)(8) are met. Multiple garnishments, attachments and executions are allowed as long as the amount levied upon does not exceed the limitations prescribed in 15 U.S.C. Section 1673(b).

16.1(8) IPERS may release information relating to entitlement to funds to a court or to the Iowa department of human services prior to receipt of a valid garnishment, attachment, execution, or income withholding order when presented with a written request stating the information requested and reasons for the request. This request must be signed by a magistrate, judge, or child support recovery unit director or the director’s designee, including an attorney representing the Iowa department of human services. In addition, IPERS may release information to the Iowa department of human services through automated matches.

495—16.2(97B) Domestic relations orders. This rule shall apply only to marital property orders. All support orders shall continue to be administered under rule 495—16.1(97B).

16.2(1) Definitions.

“*Administrable domestic relations order*” or “*ADRO*” means a domestic relations order that divides the marital property of same gender spouses, assigns to same gender alternate payees the right to receive all or a portion of the benefits payable with respect to a member under IPERS, and meets the requirements of this rule.

“*Alternate payee*” means a spouse or former spouse, regardless of gender, of a member who is recognized by a domestic relations order as having a right to receive all or a portion of the benefits payable by IPERS with respect to such member.

“*Benefits*” means, for purposes of this rule and depending on the context, a refund, monthly allowance (including monthly allowance paid as an actuarial equivalent (AE)), or death benefit payable with respect to a member covered under IPERS. “Benefits” does not include dividends payable under

Iowa Code section 97B.49 or other cost-of-living increases unless specifically provided for in a QDRO or an ADRO.

“*Domestic relations order*” means any judgment, decree, or order which relates to the provision of marital property rights to a spouse or former spouse, regardless of gender, of a member and is made pursuant to the domestic relations laws of a state.

“*Member*” means, for purposes of this rule, IPERS members, beneficiaries, and contingent annuitants.

“*Qualified domestic relations order*” or “*QDRO*” means a domestic relations order that divides the marital property of opposite gender spouses and assigns to an opposite gender alternate payee the right to receive all or a portion of the benefits payable with respect to a member under IPERS and meets the requirements of this rule.

“*Same gender spouse*” or “*same gender former spouse*” means a spouse or former spouse who is the same sex as the member.

“*Successor alternate payee*” means a person or persons named in a domestic relations order to receive the amounts payable to the alternate payee under the QDRO or ADRO if the alternate payee dies before the member. Successor alternate payees must be named individuals, not a class of individuals, a trust or an estate.

“*Trigger event*” means a distribution or series of distributions of benefits made with respect to a member.

16.2(2) Requirements.

a. Mandatory provisions. A domestic relations order is a QDRO or an ADRO if such order:

(1) Clearly specifies the member’s name and last-known mailing address, member identification number or social security number, and the names and last-known mailing addresses and social security numbers of alternate payees. This information shall be provided to IPERS in a cover letter or a court’s Confidential Information Form;

(2) Clearly specifies a fixed dollar amount or a percentage, but not both, of the member’s benefits to be paid by IPERS to the alternate payee or the manner in which the fixed dollar amount or percentage is to be determined, provided that no such method shall require IPERS to perform present value calculations of the member’s accrued benefit;

(3) Clearly specifies the period to which such order applies;

(4) Clearly specifies that the order applies to IPERS;

(5) Clearly specifies that the order is for purposes of making a property division; and

(6) Is clearly signed by the judge and filed with the clerk of court. IPERS will consider an order duly signed if it carries an original signature, a stamp bearing the judge’s signature, or is conformed in accordance with local court rules.

b. Prohibited provisions. A domestic relations order is not a QDRO or an ADRO if such order:

(1) Requires IPERS to provide any type or form of benefit or any option not otherwise provided under Iowa Code chapter 97B;

(2) Requires IPERS to provide increased benefits determined on the basis of actuarial value;

(3) Requires the payment of benefits to an alternate payee which are required to be paid to another alternate payee under another order previously determined by IPERS to be a QDRO or an ADRO;

(4) Requires any action by IPERS that is contrary to its governing statutes or plan provisions;

(5) Awards any future benefit increases that are provided by the legislature, except as provided in subparagraph 16.2(2)“c”(2); or

(6) Requires the payment of benefits to an alternate payee prior to a trigger event.

c. Permitted provisions. A QDRO or an ADRO may also:

(1) If a trigger event has not occurred as of the date the order is received by IPERS, name an alternate payee as a designated beneficiary or contingent annuitant, require the payment of benefits under a particular benefit option, or both;

(2) Specify that the alternate payee shall be entitled to a fixed dollar amount or percentage of dividend payments, or cost-of-living increase or any other postretirement benefit increase to the member (all known as dividend payments), as follows:

1. If the court order awards a fixed dollar amount of benefits to the alternate payee, the dollar amount of dividend payments to be added or method for determining said dollar amount shall be stated in the court order or an award of a share of dividend payments shall be given no effect; and

2. If the court order awards a specified percentage of benefits to the alternate payee, IPERS shall add dividends to the alternate payee's share of the retirement allowance as necessary to keep the alternate payee's share of payments at the percentage specified in the court order;

(3) Bar a vested member from requesting a refund of the member's accumulated contributions without the alternate payee's written consent;

(4) Allow benefits to be paid to an alternate payee based on a period of reemployment for a retired member; and

(5) Name a successor alternate payee to receive the amounts that would have been payable to the member's spouse or former spouse under the order, if the alternate payee dies before the member. The designation of a successor alternate payee in an order shall be void and be given no effect if IPERS does not receive confirmation of the successor's name, social security number, and last-known mailing address in a cover letter or in a copy of the court's confidential information form. A QDRO or an ADRO that lists a series of default successor alternate payees by class or permits a successor alternate payee to designate additional successor alternate payees is not permitted and will be rejected. Once a QDRO or an ADRO is accepted by IPERS for administration, in order to change the designation of successor alternate payees, an amended order is required.

16.2(3) Administrative provisions.

a. IPERS uses the shared payment method for payments under a domestic relations order. IPERS will not create a separate account for the alternate payee. Payment to the alternate payee shall be in a lump sum if the member's benefits are paid in a lump sum distribution or as monthly payments if the member's benefits are paid under a retirement option. A member shall not be able to receive an actuarial equivalent (AE) under Iowa Code section 97B.48(1) unless the total benefit payable with respect to that member meets the applicable requirements. All divisions of benefits shall be based on the gross amount of monthly or lump sum benefits payable. Federal and state income taxes shall be deducted from the member's and alternate payee's respective shares and reported under their respective federal tax identification numbers. Unrecovered basis shall be allocated on a pro rata basis to the member and alternate payee.

b. The alternate payee shall not be entitled to any share of the member's death benefits except to the extent such entitlement is recognized in a QDRO or an ADRO or in a beneficiary designation filed subsequent to the dissolution.

c. If a QDRO or an ADRO directs the member to name the alternate payee under the order as a designated beneficiary, and the member fails to do so, the provisions of the QDRO or ADRO awarding the alternate payee a share of the member's death benefit shall be deemed, except as revoked or modified in a subsequent QDRO or ADRO, to operate as a beneficiary designation, and shall be given first priority by IPERS in the determination and payment of such member's death benefits. Death benefits remaining after payments required by the QDRO or ADRO, to the extent possible, shall then be made according to the terms of the member's most recent beneficiary designation. If a QDRO or an ADRO does not require the member to select an option, the member is allowed to select any option at retirement.

d. If an alternate payee has been awarded a share of the member's benefits and dies before the member, the entire account value shall be restored to the member unless otherwise specified in the order and in the manner required under this rule.

e. An alternate payee shall not receive a share of dividends or other cost-of-living increases, unless so provided in a QDRO or an ADRO.

f. The CEO, or CEO's designee, shall have exclusive authority to determine whether a domestic relations order is a QDRO or an ADRO. A final determination by the CEO, or CEO's designee, may be appealed in the same manner as any other final agency determination under Iowa Code chapter 97B.

g. A person who attempts to make IPERS a party or requires IPERS to appear as a witness to a domestic relations action in order to determine an alternate payee's right to receive a portion of the benefits payable to a member shall be liable to IPERS for its costs and attorney's fees.

h. A domestic relations order shall not become effective until it is approved by IPERS. If a member is receiving a retirement allowance at the time a domestic relations order is received by the system, the order shall be effective only with respect to payments made after the order is determined to be a QDRO or an ADRO. If distributions have already begun at the time that an order is determined by IPERS to be a QDRO or an ADRO, the order shall be deemed to be the alternate payee's application to begin receiving payments under the QDRO or ADRO. Payment to the alternate payee will be paid for the month the order is accepted by IPERS. If the member is not receiving a retirement allowance at the time a domestic relations order is approved by IPERS and the member applies for a refund or monthly allowance, or dies, no distributions shall be made until the respective rights of the parties under the domestic relations order are determined by IPERS. If IPERS has placed a hold on the member's account following written or verbal notification from the member, member's spouse, or legal representative of either party of a pending dissolution of marriage, and no further contacts are received from either party or their representatives within the following one-year period, IPERS shall release the hold.

i. IPERS and its staff shall have no liability for making or withholding payments in accordance with the provisions of this rule.

j. IPERS has no duty or responsibility to search for alternate payees. Alternate payees must notify IPERS of any change in their mailing addresses. IPERS shall contact the alternate payee in writing, notifying the alternate payee that an application for a distribution has been requested by the member. IPERS shall send the alternate payee an application to be completed and returned to IPERS. The written notice shall inform the alternate payee that if the alternate payee does not return the application to IPERS within 60 days after the materials are mailed by IPERS, the amounts otherwise payable to the alternate payee shall be paid to the member or the member's beneficiary(ies) until a valid application is received and accepted by IPERS. IPERS shall have no liability to the alternate payee with respect to payment of such amounts.

k. If a QDRO or an ADRO requires the member to select an option with joint and survivor provisions (Option 4 or 6) and name the alternate payee as contingent annuitant, the order must state the percentage in Option 4 or 6 to be payable to the alternate payee as contingent annuitant (the currently available percentages under Option 4 or 6 are 25, 50, 75 and 100 percent). Acceptable birth proof for the alternate payee as the named contingent annuitant, pursuant to 495—subrule 11.1(2), must also be provided to IPERS prior to approval of the order by IPERS.

l. For both lump sum and monthly payments, the alternate payee's tax withholding and rollover elections, if eligible, must be received before the first or current month's benefit is certified for payment or IPERS will use the applicable default tax withholding elections.

m. If an order that is determined to be a QDRO or an ADRO divides a member's account using a service factor formula and the member's IPERS benefits are based on a number of quarters less than the member's total covered quarters, notwithstanding any terms of the order to the contrary, IPERS shall limit the number of quarters used in the numerator and the denominator of the service fraction to the number of quarters actually used in the calculation of IPERS benefits.

n. Service credit that is purchased during the period when the member is married to the alternate payee shall be added to the numerator and the denominator of the service fraction when calculating the service factor pursuant to a domestic relations order. Service credit that is purchased during a period when the member is not married to the alternate payee shall only be added to the denominator of the service fraction when calculating the service factor pursuant to a domestic relations order. Under no circumstances shall the number of quarters in the denominator be more than the number of quarters used to calculate the member's benefit.

o. The parties or their attorneys in a dissolution action involving an IPERS member shall decide between themselves which attorney will submit a proposed domestic relations order to IPERS for review. IPERS shall not review a proposed order that has not been approved as to form by both parties or their counsel. A rejection under this paragraph shall not preclude IPERS from placing a hold on a member's account until the status of a proposed order as a QDRO or an ADRO is resolved.

p. If a domestic relations order has been determined by the system to be an ADRO, before the system will accept the ADRO for current or deferred administration, the alternate payee under that final

order shall be required to complete any forms required by IPERS for purposes of determining the proper tax treatment of current or future distributions to that alternate payee in accordance with federal laws governing such distributions.

q. If a member with an IPERS-approved QDRO or ADRO is receiving a distribution according to a qualified benefits arrangement (QBA), the alternate payee shall share in the distribution to the member unless the order specifically states otherwise.

[ARC 8601B, IAB 3/10/10, effective 4/14/10; ARC 8929B, IAB 7/14/10, effective 6/21/10; ARC 9068B, IAB 9/8/10, effective 10/13/10; ARC 9397B, IAB 2/23/11, effective 3/30/11; ARC 0662C, IAB 4/3/13, effective 5/8/13]

These rules are intended to implement Iowa Code sections 97B.4, 97B.15, 97B.25, 97B.38 and 97B.39.

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CHAPTER 4
CENTER FOR CONGENITAL AND INHERITED DISORDERS
[Prior to 7/29/87, Health Department[470]]

641—4.1(136A) Program overview. The center for congenital and inherited disorders within the department of public health provides administrative oversight to the following: Iowa newborn screening program, expanded maternal serum alpha-fetoprotein screening program, regional genetic consultation service, neuromuscular and related genetic disease program and Iowa registry for congenital and inherited disorders.

4.1(1) Advisory committee. The center for congenital and inherited disorders advisory committee represents the interests of the people of Iowa and assists in the development of programs that ensure the availability of and access to quality genetic and genomic health care services by all residents. The committee advises the director of the department of public health regarding issues related to genetics and hereditary and congenital disorders and makes recommendations about the design and implementation of the center's programs.

4.1(2) Genetics coordinator. The state genetics coordinator assigned within the department provides administrative oversight to the center for congenital and inherited disorders program within Iowa.

4.1(3) Title V. The center for congenital and inherited disorders has an association with the state Title V maternal child health program to promote comprehensive services for women, infants and children. [ARC 0664C, IAB 4/3/13, effective 5/8/13]

641—4.2(136A) Definitions. For the purposes of this chapter, the following definitions shall apply:

"Anonymized specimen" means a specimen that cannot be traced back to or linked with the particular individual from whom the specimen was obtained.

"Attending health care provider" means the licensed physician, nurse practitioner, certified midwife or physician assistant providing care to an infant at birth.

"Birthing facility" means a private or public facility licensed pursuant to Iowa Code chapter 135B that has a licensed obstetric unit or is licensed to provide obstetric services.

"Center" means the center for congenital and inherited disorders within the Iowa department of public health.

"Central laboratory" means the state hygienic laboratory (SHL), which is designated as the screening laboratory to perform testing and reporting for the Iowa newborn screening and Iowa maternal prenatal screening programs.

"Central registry" means the Iowa registry for congenital and inherited disorders (IRCID).

"Committee" means the center for congenital and inherited disorders advisory committee.

"Consulting physician" means a physician designated by the center for congenital and inherited disorders to interpret screen results and provide consultation to a licensed health care provider.

"Department" means the Iowa department of public health.

"Director" means the director of the Iowa department of public health.

"Discharge" means a release of an infant from a hospital or birth center.

"Early ACCESS" means Iowa's Individuals with Disabilities Education Act (IDEA), Part C, program for infants and toddlers. Early ACCESS is a statewide, comprehensive, interagency system of integrated early intervention services that supports eligible children and their families as defined in 281—Chapter 120.

"Follow-up program" means the services provided to follow up on an abnormal screening result.

"Guardian" means a person who is not the parent of a minor child, but who has legal authority to make decisions regarding life or program issues for the child.

"Health care provider" means a licensed physician, nurse practitioner, certified nurse midwife, registered nurse, or physician assistant providing medical care to an individual.

"Iowa maternal prenatal screening program" or *"IMPSP"* means a program that provides a screening test designed to identify women with an increased risk of having a baby with a congenital or inherited disorder or women at risk of developing a problem later in pregnancy.

“*Primary health care provider*” means a licensed physician, physician assistant, nurse practitioner, or certified nurse midwife providing primary medical care to a patient.

“*Receiving facility*” means the facility receiving an infant from a birthing facility.

“*Residual maternal prenatal serum screening specimen*” means the portion of the specimen that may be left over after all necessary activities of the Iowa maternal prenatal screening program are completed.

“*Residual newborn screening specimen*” means the portion of the specimen that may be left over after all activities necessary for the Iowa newborn screening program are completed.

“*Specialty genetics provider*” means a geneticist, genetic nurse, or genetic counselor.

“*State hygienic laboratory*” or “*SHL*” means the designated central testing laboratory.

“*Transferring facility*” means the birthing facility that transfers the infant to another facility.

[ARC 7981B, IAB 7/29/09, effective 9/2/09; ARC 0664C, IAB 4/3/13, effective 5/8/13]

641—4.3(136A) Iowa newborn screening program (INSP). This program provides comprehensive newborn screening services for hereditary and congenital disorders for the state.

4.3(1) *Newborn screening policy.*

a. All newborns and infants born in the state of Iowa shall be screened for all congenital and inherited disorders specified by the center and approved by the state board of health.

b. As new disorders are recognized and new technologies and tests become available, the center shall follow protocols developed by the department in regard to the addition of disorders to or the deletion of disorders from the screening panel. The state board of health shall provide final approval for the addition of disorders to or the deletion of disorders from the screening panel.

c. The center may monitor individuals identified as having a genetic or metabolic disorder for the purpose of conducting public health surveillance or intervention and for determining whether early detection, treatment, and counseling lead to the amelioration or avoidance of the adverse outcomes of the disorder. Birthing facilities and health care providers shall provide patient data and records to the center upon request to facilitate the monitoring. Any identifying information provided to the center shall remain confidential pursuant to Iowa Code section 22.7(2).

4.3(2) *Neonatal metabolic screening procedure for facilities and providers.*

a. *Educating parent or guardian.* Before a specimen from an infant is obtained, a parent or guardian shall be informed of the type of specimen, how it is obtained, the nature of the disorders for which the infant is being screened, the consequences of treatment and nontreatment, and the retention, use and disposition of residual specimens.

b. *Waiver.* Should a parent or guardian refuse the screening, said refusal shall be documented in the infant’s medical record, and the parent or guardian shall sign the refusal of screening waiver. The birthing facility or attending health care provider shall submit the signed refusal of screening waiver to the central laboratory within six days of the refusal.

c. *Collection of specimens.* A filter paper blood specimen shall be collected from the infant between 24 to 48 hours after the infant’s birth. A specimen shall not be collected from an infant less than 24 hours after birth except as follows:

(1) A blood specimen must be collected before any initial transfusion, even if the infant is less than 24 hours old.

(2) A blood specimen must be collected before the infant leaves the hospital, whether by discharge or by transfer to another hospital, even if the infant is less than 24 hours old.

d. *Submission of specimens.* All specimens shall be delivered via courier service or, if courier service is not available, forwarded by first-class mail or other appropriate means within 24 hours after collection to the SHL.

e. *Waiver for the release of residual specimens for research use.* The department shall establish policies and procedures, including a refusal for research waiver form, to allow a parent or guardian the ability to refuse the release of the newborn’s residual newborn screening specimen for research purposes. The birthing facility or attending health care provider shall submit the signed refusal for research waiver to the central laboratory pursuant to established policy and procedure.

4.3(3) Primary health care provider responsibility.

- a. The health care provider shall ensure that infants under the provider's care are screened.
- b. Procedures for specimen collection for newborn screening shall be followed in accordance with 4.3(2).
- c. A physician or other health care professional who undertakes primary pediatric care of an infant delivered in Iowa shall arrange for the newborn screening if a newborn screening result is not in the infant's medical record.

4.3(4) Birthing facility. The birthing facility shall ensure that all infants receive newborn screening.

- a. Designee. Each birthing facility shall designate an employee to be responsible for the newborn screening program in that institution.
- b. Procedures for specimen collection for newborn screening shall be followed in accordance with 4.3(2).
- c. Transfer. The following shall apply if an infant is transferred:
 - (1) If an infant is transferred within the hospital for acute care, the newborn nursery shall notify the acute care unit of the status of the newborn screening. The acute care unit shall then be responsible for the status of the newborn screening prior to discharge of the infant.
 - (2) If the infant is transferred to another facility within the state, the facility shall notify the receiving facility of the status of the newborn screening. The receiving facility shall then be responsible for completion of the newborn screening prior to discharge of the infant.
- d. Discharge. Each birthing facility shall collect a newborn screening specimen on every infant prior to discharge, including under the following circumstances:
 - (1) The infant is discharged or transferred to another facility before the infant is 24 hours old.
 - (2) The infant is born with a condition that is incompatible with life.
 - (3) The infant has received a transfusion.
- e. Notification. The birthing facility shall report the newborn screening results to the health care provider who has undertaken primary pediatric care of the infant.

4.3(5) SHL responsibility. The SHL shall:

- a. Contract with a courier service to provide transportation and delivery of newborn screening specimens.
- b. Contact all birthing facilities to inform them of the courier schedule.
- c. Process specimens within 24 hours of receipt.
- d. Notify the submitting health care provider, birthing facility, or drawing laboratory of an unacceptable specimen and the need for another specimen.
- e. Report a presumptive positive screen result within 24 hours to the consulting physician or the physician's designee.
- f. Distribute specimen collection forms, specimen collection procedures, refusal of newborn screening forms, and other materials to drawing laboratories, birthing facilities, and health care providers.
- g. Report normal and abnormal screening results to the submitting facility or provider.
- h. Submit a written annual report of the previous calendar year to the center by July 1 of each year.

This report shall include:

- (1) Number of infants screened,
- (2) Number of repeat screens,
- (3) Number of presumptive positive results by disorder,
- (4) Number of rejected specimens,
- (5) Number of waivers,
- (6) Results of quality assurance testing including any updates to the INSP quality assurance policies, and
- (7) Screening and educational activity details.
- i. In collaboration with the program consulting physicians, submit a proposed budget and narrative justification for the upcoming state fiscal year by January 31 of each year.

j. Act as fiscal agent for program expenditures encompassing the analytical, technical, administrative, educational, and follow-up costs for the screening program.

k. Submit a fiscal expenditures report to the center within 90 days after the end of the state fiscal year.

4.3(6) *Follow-up program responsibility.* Follow-up programs shall be available for all individuals identified by the newborn screening as having an abnormal screen result.

a. The follow-up activities shall include care coordination, consultation, recommendations for treatment when indicated, case management, education and quality assurance.

b. The follow-up programs shall submit a written annual report of the previous calendar year by July 1 of each year. The report shall include:

- (1) The number of presumptive positive results and confirmed positive results by disorder,
- (2) Method and timing of referrals made to the follow-up programs,
- (3) Each individual's age at confirmation of disorder,
- (4) Each individual's age when treatment began,
- (5) Type of treatment for each individual with a disorder, and
- (6) A written summary of educational and follow-up activities.

c. In collaboration with the SHL, the follow-up programs shall submit a proposed budget and narrative justification for the upcoming fiscal year to the center by January 31 of each year.

d. The follow-up programs shall submit a fiscal expenditures report to the center within 90 days of the end of the state fiscal year.

4.3(7) *Sharing of information and confidentiality.* Reports, records, and other information collected by or provided to the Iowa newborn screening program relating to an infant's newborn screening results and follow-up information are confidential records pursuant to Iowa Code section 22.7.

a. Personnel of the program shall maintain the confidentiality of all information and records used in the review and analysis of newborn screening and follow-up, including information that is confidential under Iowa Code chapter 22 or any other provisions of state law.

b. The program shall not release confidential information except to the following persons and entities, under the following conditions:

- (1) The parent or guardian of an infant or child for whom the report is made.
- (2) A primary health care provider, birthing facility, or submitting laboratory.
- (3) A representative of a state or federal agency, to the extent that the information is necessary to perform a legally authorized function of that agency or the department. The state or federal agency will be subject to confidentiality regulations which are the same as or more stringent than those in the state of Iowa.
- (4) A researcher, upon documentation of parental consent obtained by the researcher, and only to the extent that the information is necessary to perform research authorized by the department.

4.3(8) *Retention, use and disposition of residual newborn screening specimens.*

a. A newborn screening specimen collection form consists of a filter paper containing the dried blood spots (DBS) specimen and the attached requisition that contains information about the infant and birthing facility or drawing laboratory. The DBS specimen can be separated from the information contained in the requisition form.

- (1) The residual DBS specimen shall be held for five years in a locked area at the SHL.
- (2) The residual DBS specimen shall be stored for the first year at -70 degrees C.
- (3) After one year, the residual DBS specimen shall be archived for four additional years at room temperature.
- (4) The residual DBS specimen shall be incinerated after completion of the retention period.

b. Research use.

(1) Investigators shall submit proposals to use residual DBS specimens to the center. Any intent to utilize information associated with the requested specimens as part of the research study must be clearly delineated in the proposal.

(2) Before research can commence, proposals shall be approved by the researcher's institutional review board, the congenital and inherited disorders advisory committee, and the department.

(3) Personally identifiable residual specimens or records shall not be disclosed without documentation of informed parental consent obtained by the researcher.

(4) Research on anonymized or identifiable residual specimens shall be allowed in instances where research would further: newborn screening activities; the health of an infant or child for whom no other specimens are available or readily attainable; or general medical knowledge for existing public health surveillance activities.

4.3(9) INSP fee determination.

a. The department shall annually review and determine the fee to be charged for all activities associated with the INSP. The review and fee determination shall be completed at least one month prior to the beginning of the fiscal year. The newborn screening fee is \$122.

b. The department shall include as part of this fee an amount determined by the committee and department to fund the provision of special medical formula and foods for eligible individuals with inherited diseases of amino acids and organic acids who are identified through the program.

4.3(10) Special medical formula and foods program.

a. A special medical formula and foods program for individuals with inherited diseases of amino acids and organic acids who are identified through the Iowa newborn screening program is provided by the University of Iowa.

b. Payments received from clients based on third-party payment, sliding fee scales and donations shall be used to support the administration of and the purchase of special medical formula and foods.

c. The funding allocation from the Iowa newborn screening program fee will be used as the funder of last resort after all other available funding options have been pursued by the special medical formula and foods program.

d. Provisions of special medical formula and foods through this funding allocation shall be available to an individual only after the individual has shown that all benefits from third-party payers including, but not limited to, health insurers, health maintenance organizations, Medicare, Medicaid, WIC and other government assistance programs have been exhausted. In addition, a full fee and a sliding fee scale shall be established and used for those persons able to pay all or part of the cost. Income and resources shall be considered in the application of the sliding fee scale. Individuals whose income is at or above 185 percent of the federal poverty level shall be charged a fee for the provision of special medical formula and foods. Placement of individuals on the sliding fee scale shall be determined and reviewed at least annually.

e. The SHL shall act as the fiscal agent.

f. The University of Iowa Hospitals and Clinics under the control of the state board of regents shall not receive indirect costs from state funds appropriated for this program.

[ARC 7981B, IAB 7/29/09, effective 9/2/09; ARC 0664C, IAB 4/3/13, effective 5/8/13]

641—4.4(136A) Iowa maternal prenatal screening program (IMPSP). This program provides comprehensive maternal prenatal screening services for the state.

4.4(1) Maternal screening policy. It shall be the policy of the state of Iowa that all pregnant women are offered maternal prenatal screening. The Iowa maternal prenatal screening program provides a risk assessment for open neural tube defects, ventral wall defects, Down syndrome, and Trisomy 18.

a. If a patient desires this screening test, her health care provider shall direct that a specimen be drawn and submitted to the SHL.

b. As new technologies and tests become available, the center shall follow protocols developed by the department with regard to the addition of disorders to or the deletion of disorders from the screening program.

4.4(2) Maternal screening procedure.

a. *Collection of specimens.* A serum or clotted blood specimen shall be collected from the patient within the appropriate gestational range indicated by the requested screen.

b. *Processing of specimens.* The SHL shall test specimens within three working days of receipt.

c. *Reporting of abnormal results.* Abnormal screen results shall be reported within 24 hours to the consulting physician or the physician's designee who shall then notify the primary health care provider.

On the next working day, this initial report shall be followed by a written report to the primary health care provider.

4.4(3) Consulting physician responsibility. A consulting physician shall be designated by the center in collaboration with the SHL to provide interpretation of screen results and consultation to the submitting health care provider. This physician shall provide consultation for abnormal screen results, assist with questions about management of identified cases, provide education and assist with quality assurance measures. The screening program, with assistance from the consulting physician, shall:

a. In collaboration with the SHL, submit a proposed budget and narrative justification for the upcoming fiscal year to the center by January 31 of each year, and

b. Submit a written annual report of the previous calendar year to the center by July 1 of each year.

The report shall include:

- (1) Number of women screened,
- (2) Number of repeat screens,
- (3) Number of abnormal results by disorder,
- (4) Number of rejected specimens,
- (5) Results of quality assurance testing, and
- (6) Screening and educational activity details.

4.4(4) SHL responsibility. The SHL shall:

a. Contract with a courier service to provide transportation and delivery of maternal prenatal serum specimens.

b. Contact all entities submitting specimens to inform them of the courier's schedule.

c. Test specimens within three working days of receipt.

d. Distribute specimen collection kits and other materials to health care provider offices and drawing facilities as required.

e. Inform the submitting health care provider or drawing facility of an unacceptable specimen and request another specimen.

f. Provide educational materials concerning specimen collection procedures.

g. Have available for review a written quality assurance program covering all aspects of its screening activity.

h. Act as a fiscal agent for program charges encompassing the analytical, technical, administrative, educational and follow-up costs for the screening program.

4.4(5) IMPSP fee determination. The department shall annually review and determine the fee to be charged for all activities associated with the IMPSP. The review and determination of the fee shall be completed at least one month prior to the beginning of the fiscal year.

4.4(6) Sharing of information and confidentiality. Reports, records, and other information collected by or provided to the IMPSP relating to a patient's maternal prenatal screening results and follow-up information are confidential records pursuant to Iowa Code section 22.7.

a. Personnel of the program shall maintain the confidentiality of all information and records used in the review and analysis of maternal serum screening and follow-up, including information that is confidential under Iowa Code chapter 22 or any other provisions of state law.

b. The program shall not release confidential information except to the following persons and entities, under the following conditions:

(1) The patient for whom the report is made.

(2) A primary health care provider or submitting laboratory.

(3) A representative of a state or federal agency, to the extent that the information is necessary to perform a legally authorized function of that agency or the department. The state or federal agency will be subject to confidentiality regulations which are the same as or more stringent than those in the state of Iowa.

(4) A researcher, upon documentation of patient consent obtained by the researcher, and only to the extent that the information is necessary to perform research authorized by the department and the state board of health.

4.4(7) Retention, use and disposition of residual maternal prenatal screening specimens.

a. A maternal serum screening specimen collection consists of laboratory tubes with maternal serum and associated information about the patient, health care provider, or drawing laboratory.

(1) The residual serum specimens shall be held for a specified period of time in a locked area at the SHL in accordance with SHL policy and procedures.

(2) Reserved.

b. Research use.

(1) Investigators shall submit proposals to use residual serum specimens to the center. Any intent to utilize information associated with the requested specimens as part of the research study must be clearly delineated in the proposal.

(2) Before research can commence, proposals shall be approved by the researcher's institutional review board, the congenital and inherited disorders advisory committee, and the department.

(3) Personally identifiable residual specimens or records shall not be disclosed without documentation of informed patient consent obtained by the researcher.

(4) Research on anonymized or identifiable residual specimens shall be allowed in instances where research would further maternal prenatal screening activities or general medical knowledge for existing public health surveillance activities.

[ARC 7981B, IAB 7/29/09, effective 9/2/09; ARC 0664C, IAB 4/3/13, effective 5/8/13]

641—4.5(136A) Regional genetic consultation service (RGCS). This program provides comprehensive genetic and genomic services statewide through outreach clinics.

4.5(1) Provision of comprehensive genetic and genomic services. The department shall contract with the division of medical genetics within the department of pediatrics at the University of Iowa to provide genetic and genomic health care and education outreach services for individuals and families within Iowa. The contractor shall provide annual reports to the department as specified in the contract.

4.5(2) Clinical services. The services provided may include, but are not limited to: diagnostic evaluations, confirmatory testing, consultation by board-certified geneticists, genetic counseling, medical case management, and referral to appropriate agencies.

4.5(3) The University of Iowa Hospitals and Clinics under the control of the state board of regents shall not receive indirect costs from state funds appropriated for this program.

[ARC 0664C, IAB 4/3/13, effective 5/8/13]

641—4.6(136A) Neuromuscular and other related genetic disease program (NMP). This program provides comprehensive services statewide for individuals and families with neuromuscular disorders through outreach clinics and statewide, active surveillance for selected neuromuscular disorders.

4.6(1) Provision of comprehensive services. The department shall contract with the department of pediatrics at the University of Iowa to provide neuromuscular health care, case management and education outreach services for individuals and families within Iowa. The contractor shall provide annual reports to the department as specified in the contract.

4.6(2) Clinical services. The services provided may include, but are not limited to: diagnostic evaluations, confirmatory testing, physical therapy, consultation by board-certified neurologists, genetic counseling, medical case management, supportive services and referral to appropriate agencies.

4.6(3) Patient fees.

a. A sliding fee scale for specialty genetic provider services shall be established for patients attending the outreach clinics. The parameters for the sliding fee scale shall be based on federally established percent of poverty guidelines and updated annually.

b. Families/clients seen in neuromuscular outreach clinics shall have bills submitted to third-party payers where applicable. Families/clients shall be billed on a sliding fee scale after third-party payment is received. Payments received from receipts of service based on the sliding fee scale or from the third-party payers shall be used only to support the neuromuscular outreach clinics.

c. The University of Iowa Hospitals and Clinics under the control of the state board of regents shall not receive indirect costs from state funds appropriated for this program.

[ARC 7981B, IAB 7/29/09, effective 9/2/09]

641—4.7(136A) Iowa registry for congenital and inherited disorders (IRCID). This program provides active statewide surveillance for congenital and inherited disorders. These disorders may include birth defects, neuromuscular disorders, metabolic disorders, and all stillbirths. The program also may conduct active statewide surveillance of live births without a reportable congenital or inherited disorder to serve as controls for epidemiological surveys. Surveillance activities for specific congenital and inherited disorders will be conducted for the period of time that adequate financial support is available.

4.7(1) Definitions.

a. Birth defects shall be defined as any major structural abnormality or metabolic disorder that may adversely affect a child's health and development. The abnormality or disorder must be diagnosed or its signs and symptoms must be recognized within the first two years of life.

b. Neuromuscular disorders shall be defined as Duchenne, Becker, congenital, distal, Emery-Dreifuss, fascioscapulohumeral, limb-girdle, myotonic, and oculopharyngeal muscular dystrophies.

c. Rescinded IAB 4/3/13, effective 5/8/13.

d. Stillbirths shall be defined as an unintended fetal death occurring after a gestational period of 20 completed weeks or an unintended fetal death of a fetus with a weight of 350 or more grams. Stillbirth is synonymous with fetal death.

e. A reportable congenital or inherited disorder occurring in a miscarriage or pregnancy may be included in the IRCID.

4.7(2) Surveillance policy.

a. Congenital disorders, including birth defects, occurring in Iowa are reportable conditions, and records of these disorders shall be abstracted pursuant to 641—1.3(139A) and maintained in the IRCID. Congenital disorders surveillance shall be performed in order to determine the occurrence and trends of such disorders, to determine co-occurring conditions and treatments through annual follow-up abstraction, to conduct thorough and complete epidemiological surveys to identify environmental and genetic risk factors for congenital disorders, to contribute to prevention strategies, and to assist in the planning for and provision of services to children with congenital disorders and their families.

b. Records for neuromuscular disorders shall be abstracted pursuant to 641—1.3(139A) and maintained in the IRCID. Neuromuscular disorders surveillance for individuals of all ages shall be performed in order to determine the occurrence and trends of the selected neuromuscular disorders, to determine co-occurring conditions and treatments through annual follow-up abstraction, to conduct thorough and complete epidemiological surveys through annual long-term follow-up, and to assist in the planning for and provision of services to individuals with selected neuromuscular disorders and their families.

c. Rescinded IAB 4/3/13, effective 5/8/13.

d. Stillbirths occurring in Iowa are reportable conditions, and records of these stillbirths shall be abstracted pursuant to 641—1.3(139A) and maintained in the IRCID. Stillbirth surveillance shall be performed in order to determine the occurrence and trends of stillbirths, to conduct thorough and complete epidemiological surveys to identify environmental and genetic risk factors for stillbirths, and to assist in the planning for and provision of services to prevent stillbirths.

4.7(3) IRCID activities.

a. The center shall establish an agreement with the University of Iowa to implement the activities of the IRCID.

b. The IRCID shall use the birth defects, neuromuscular disorders, metabolic disorders, and stillbirth coding schemes developed by the Centers for Disease Control and Prevention (CDC).

c. The IRCID staff shall review hospital records, clinical charts, physician's records, vital records, prenatal records, and fetal death evaluation protocols pursuant to 641—1.3(139A), information from the INSP, RGCS, NMP, and the IMPSP, and any other information that the IRCID deems necessary and appropriate for congenital and inherited disorders surveillance.

4.7(4) Department responsibility.

a. When a live infant's medical records are ascertained by the IRCID, the department or its designee shall inform the parent or legal guardian by letter that this information has been collected and provide the parent or guardian with information about services for which the child and family may be eligible.

b. The center and the IRCID shall annually release aggregate medical and epidemiological information to medical personnel and appropriate state and local agencies for the planning and monitoring of services for children with congenital or inherited disorders and their families.

4.7(5) Confidentiality and disclosure of information. Reports, records, and other information collected by or provided to the IRCID relating to a person known to have or suspected of having a congenital or inherited disorder are confidential records pursuant to Iowa Code sections 22.7 and 136A.7.

a. Personnel of the IRCID and the department shall maintain the confidentiality of all information and records used in the review and analysis of congenital or inherited disorders, including information which is confidential under Iowa Code chapter 22 or any other provisions of state law.

b. IRCID staff are authorized pursuant to 641—1.3(139A) to gather all information relevant to the review and analysis of congenital or inherited disorders. This information may include, but is not limited to, hospital records, physician's records, clinical charts, vital records, prenatal records, fetal death evaluation protocols, information from the INSP, RGCS, NMP, and the IMPSP, and any other information that the IRCID deems necessary and appropriate for congenital and inherited disorders surveillance. IRCID staff are permitted to review hospital records, clinical charts, physician's records, vital records, and prenatal records, information from the INSP, RGCS, NMP, and IMPSP and any other information that the IRCID deems necessary and appropriate for live births without a reportable congenital or inherited disorder to serve as controls for epidemiological surveys.

c. No individual or organization providing information to the IRCID in accordance with this rule shall be deemed or held liable for divulging confidential information.

4.7(6) Access to information in the IRCID. The IRCID and the department shall not release confidential information except to the following, under the following conditions:

a. The parent or guardian of an infant or child for whom the report is made and who can demonstrate that the parent or guardian has received the notification letter.

b. An Early ACCESS service coordinator or an agency under contract with the department to administer the children with special health care needs program, upon receipt of written consent from the parent or guardian of the infant or child.

c. A local health care provider, upon receipt of written consent from the parent or guardian of the infant or child.

d. A representative of a federal agency, to the extent that the information is necessary to perform a legally authorized function of that agency or the department. The information provided shall not include the personal identifiers of an infant or child with a reportable congenital or inherited disorder.

e. Researchers, in accordance with the following:

(1) All proposals for research using the IRCID data to be conducted by persons other than program staff shall first be submitted to and accepted by the researcher's institutional review board. Proposals shall then be reviewed and approved by the department and the IRCID's internal advisory committee before research can commence.

(2) The IRCID shall submit to the IRCID's internal advisory committee for approval a protocol describing any research conducted by the IRCID in which the IRCID deems it necessary to contact case subjects and controls.

f. A representative of a state agency, to the extent that the information is necessary to perform a legally authorized function of that agency or the department. The state agency will be subject to confidentiality regulations that are the same as or more stringent than those in the state of Iowa.

[ARC 7981B, IAB 7/29/09, effective 9/2/09; ARC 0664C, IAB 4/3/13, effective 5/8/13]

CENTER FOR CONGENITAL AND INHERITED DISORDERS ADVISORY COMMITTEE (CIDAC)

641—4.11(136A) Purpose. CIDAC represents the interests of the people of Iowa and assists in the development of programs that ensure the availability of and access to quality genetic and genomic health care services by all residents. The committee advises the director regarding issues related to genetics and hereditary and congenital disorders.

[ARC 0664C, IAB 4/3/13, effective 5/8/13]

641—4.12(136A) Duties of the committee. CIDAC shall perform the following duties:

4.12(1) Make recommendations about the design and implementation of the center's programs, including but not limited to:

- a. The Iowa newborn screening program;
- b. The regional genetics consultation service;
- c. The maternal prenatal screening program;
- d. The neuromuscular and related genetic disorders program; and
- e. The Iowa registry for congenital and inherited disorders.

4.12(2) Support the development of special projects and conferences regarding genetic and genomic health care services and issues.

4.12(3) Advocate for quality genetic and genomic health care services for all residents in the state of Iowa.

[ARC 0664C, IAB 4/3/13, effective 5/8/13]

641—4.13(136A) Membership. Membership will be comprised of representatives of professional groups, agencies, legislators, parents, consumers, and professional health care providers.

4.13(1) CIDAC shall be comprised of regular, ex officio, and honorary members.

a. Potential regular members are considered from interest groups, consumer organizations, and genetic and genomic health care service providers. Two parent representatives and two consumer representatives shall serve as regular members of CIDAC.

b. The number of regular members shall not be fewer than 15 or more than 25.

c. No more than 30 percent of regular members shall be representatives of or employed by programs that are contractors of the center for congenital and inherited disorders in the Iowa department of public health.

d. Honorary members will be comprised of two legislators, one state senator and one state representative, and others deemed appropriate by the director.

e. Ex officio members are nominated by virtue of their positions held and the organizations they represent and are appointed by the director. These members provide expert information and consultation to CIDAC.

4.13(2) Every effort will be made to have gender balance and broad geographic representation on the advisory committee.

4.13(3) The director will appoint regular and honorary committee members for three fiscal years. Reappointment of regular and honorary members shall be at the discretion of the director.

[ARC 0664C, IAB 4/3/13, effective 5/8/13]

641—4.14(136A) Meetings.

4.14(1) Meetings of the committee will be held as necessary and at the call of the director or the chairperson. There shall be a minimum of four meetings per year.

4.14(2) All meetings are open to the public in accordance with the open meetings law, Iowa Code chapter 21.

4.14(3) A majority of the total number of regular members (50 percent plus one member) shall constitute a quorum. There must be a quorum of the regular members in attendance at a meeting for action to be taken.

4.14(4) Action can be taken by a vote of the regular members. Ex officio and honorary members are not eligible to vote.

4.14(5) Regular members who represent programs that are contractors of the center for congenital and inherited disorders in the department are expected to refrain from imposing undue influence on regular members and to recuse themselves from voting on issues which directly affect the operation of their programs.

4.14(6) Meeting attendance.

a. Attendance at a meeting is defined as presence at the meeting site in person, through the Iowa communications network (ICN), through webinar or web meeting, or via telephone.

b. Attendance by the regular member or the regular member's designee shall be expected at all meetings.

(1) A designee of similar standing must be able to reasonably fulfill the member's role on the committee in discussions.

(2) Designees are not eligible to vote.

c. Regular members, not designees, must attend at least two meetings per fiscal year to remain in good standing.

d. A regular member who misses more than three meetings in a fiscal year shall be deemed to have submitted a resignation.

[ARC 0664C, IAB 4/3/13, effective 5/8/13]

These rules are intended to implement Iowa Code chapter 136A.

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CHAPTER 4
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

761—4.1(22,304) General provisions.

4.1(1) Scope of chapter.

a. This chapter describes the provisions governing public access to records that are owned by or in the physical possession of the department. However, access to personnel and payroll records may also be subject to the rules of the department of administrative services.

b. This chapter does not affect the policy of the department to respond, without charge, to routine oral or written inquiries that do not involve the furnishing of records.

c. This chapter does not make available records compiled by the department in reasonable anticipation of court litigation or formal administrative proceedings. The availability of these records to the public or to any subject individual or party to such litigation or proceedings shall be governed by applicable legal and constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable regulations of the department.

4.1(2) Custodian. The custodian of a record is the person who heads the departmental office responsible for that record. The department's Records Management Manual identifies the offices that are responsible for particular records.

a. As used in this chapter, the term "custodian" includes the custodian's superiors and the custodian's designees.

b. The custodian's designees may include but are not limited to the records center and the department's general counsel.

c. The custodian of a record is authorized to provide or deny access to that record in accordance with the provisions of this chapter. However, the custodian's authority to provide access to a confidential record is limited to the persons listed in subrule 4.4(2).

4.1(3) Address of records center. The address of the department's records center is: Records Center, Office of Document Services, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

4.1(4) Records Management Manual.

a. The department's Records Management Manual contains the records management information required by Iowa Code chapter 304.

b. Chapter III of the manual contains the descriptive information on records that is required by Iowa Code section 22.11. Chapter III, as revised through 2001, is made a part of these rules.

c. The manual is available for examination and copying at the department's records center and at various other departmental offices located throughout the state. A copy of the manual may be obtained at cost from the records center.

4.1(5) Availability of open records. Open records of the department are available to the public for examination and copying unless otherwise provided by rule or statute.

4.1(6) Data processing matching. All departmental data processing systems that have common data elements can potentially match, collate and compare personally identifiable information.

4.1(7) Warranty. No warranty of the accuracy or completeness of a record is made.

4.1(8) Existing records. A request for access shall apply only to records that exist at the times the request is made and access is provided. The department is not required to create, compile or procure a record solely for the purpose of making it available. EXCEPTIONS: See Iowa Code section 22.3A and subrule 4.4(5).

4.1(9) Definitions. As used in this chapter:

"Confidential record" means a record that 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 department 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 another provision of law, but that may be disclosed upon order of the court, the 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.

“Open record” means a record other than a confidential record.

“Personally identifiable information” means information about an individual in a record that identifies the individual and is retrievable by a unique personal identifier associated with the individual.

“Public” means those persons who are not officials, employees or agents of the department.

“Record” means the whole or a part of a “public record” as defined in Iowa Code section 22.1 that is owned by or in the physical possession of the department.

“Requester” means a member of the public.

This rule is intended to implement Iowa Code chapter 22 and section 304.17.

[ARC 7909B, IAB 7/1/09, effective 7/1/09]

761—4.2(22) Statement of policy and purpose. It is the policy of the department that free and open examination of public records is generally in the public interest. The purpose of these rules is to facilitate broad public access to open records and sound determinations with respect to the handling of confidential records.

This rule is intended to implement Iowa Code chapter 22.

761—4.3(22) Access to records.

4.3(1) Submission of request for access.

a. A request for access to a record shall be submitted to the custodian of the record. If the requester does not know the identity of the custodian, the request may be submitted to the records center at the address in subrule 4.1(3). The records center will forward the request to the custodian.

b. Notwithstanding paragraph “*a*” of this subrule, any request that may be related to a potential or an actual tort claim or other litigation shall be submitted to the following address: General Counsel, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010. If the custodian receives a request of this nature, the custodian shall forward the request to the department’s general counsel.

c. If a request for access is misdirected, department personnel will forward the request to the custodian.

4.3(2) Office hours. Open records are available during customary office hours, which are 8 a.m. to 4:30 p.m., excluding Saturdays, Sundays, and legal holidays.

4.3(3) Form of request. A request for access to a record shall reasonably describe the record requested. A request for access to an open record may be made orally or in writing. A requester shall not be required to give reasons for requesting an open record.

4.3(4) Response to request. The custodian shall provide access to an open record promptly upon request. However, if the size or nature of the request makes prompt access infeasible, the custodian shall fill the request as soon as feasible and give the requester an estimate of when the record will be available.

4.3(5) Delay. Access to a record may be delayed for one of the purposes authorized by Iowa Code subsection 22.8(4) or 22.10(4). The custodian shall inform the requester of the reason for the delay and the estimated length of the delay.

4.3(6) Security of records. No person may, without permission from the custodian, search agency files or remove any record from the place where it is made available. The custodian shall supervise the examination and copying of records and protect the records from damage and disorganization. Original paper records shall be released from department custody only upon court order. At least one certified copy shall be retained in the file if the original record is released.

4.3(7) Copies. A photocopy of an open record may be made on department photocopiers. If a photocopier is not available in the office where an open record is kept, the custodian shall permit its examination in that office and, if requested, arrange to have a copy made elsewhere.

4.3(8) Fees. The department may charge fees for records as authorized by Iowa Code section 22.3 or another provision of law. Under Iowa Code section 22.3, the fee for the copying service shall not exceed the cost of providing the service.

This rule is intended to implement Iowa Code sections 22.2, 22.3, 22.4, 22.8, 22.10, and 22.11.

761—4.4(22) Access to confidential records. The following provisions are in addition to those specified in rule 761—4.3(22) and are minimum requirements. A statute or another department rule may impose additional requirements for access to certain classes of confidential records.

4.4(1) Procedure.

a. Form of request. The custodian shall ensure that there is sufficient information to provide reasonable assurance that access to a confidential record may be granted. Therefore, the custodian may require the requester to:

- (1) Submit the request in writing.
- (2) Provide proof of identity and authority to secure access to the record.
- (3) Sign a certified statement or affidavit listing the specific reasons justifying access to the record and provide any proof necessary to establish relevant facts.

b. Response to request. The custodian shall notify the requester of approval or denial of the request for access. If the requester indicates to the custodian that a written notice is desired if the request for access is denied, the custodian shall provide such notice promptly. The notice shall be signed by the custodian and include:

- (1) The name and title or position of the custodian, and
- (2) A brief statement of the grounds for denial, including a citation to the applicable statute or other provision of law.

c. Reconsideration of denial. A requester whose request is denied by the custodian may apply to the director of transportation for reconsideration of the request.

4.4(2) Release of confidential records by the custodian. The custodian may release a confidential record or a portion of it:

- a.* To the legislative services agency pursuant to Iowa Code section 2A.3.
- b.* To the citizens' aide pursuant to Iowa Code section 2C.9.
- c.* To other governmental officials and employees only as needed to discharge their duties.
- d.* To those persons as permitted or required by rule 761—4.9(22).
- e.* To persons authorized by the subject of the record in accordance with rule 761—4.5(22).

4.4(3) Release of confidential records by the director.

a. The director of transportation may release a confidential record or a portion of it to a person not covered in subrule 4.4(2) if the release:

- (1) Is permitted by statute, rule or another provision of law, and
- (2) Is not inconsistent with the stated or implied purpose of the law which establishes or authorizes confidentiality.

b. Before the director releases a record to a person not covered in subrule 4.4(2), the director may notify the subject of the record of the impending release and may give the subject a reasonable amount of time to seek an injunction.

4.4(4) Mixed record. A confidential record may, due to its nature or the way it is compiled or stored, contain a mixture of confidential and nonconfidential information. The department shall not refuse to release the nonconfidential information simply because the record is compiled or stored in this fashion.

4.4(5) Information released. If a person is provided access to less than an entire record, the department shall take measures to ensure that the person is furnished only the information that is to be released. This may be done by providing to the person either an extraction of the information to be released, or a copy of the record from which the information not to be released has been deleted.

This rule is intended to implement Iowa Code section 22.11.

761—4.5(22) Consent to release a confidential record to a third party. To the extent permitted by law, the subject of a confidential record may consent to its release to a third party. The consent must be in writing and must identify the particular record that may be disclosed and the particular person or class of persons to whom the record may be disclosed. The subject of the record may be required to provide proof of identity. Appearance of counsel before the agency on behalf of a person who is the subject of

a confidential record may be deemed to constitute consent for the department to disclose records about that person to the person's counsel.

This rule is intended to implement Iowa Code section 22.11.

761—4.6(22) Requests for confidential treatment.

4.6(1) A person may request that all or a portion of a record be confidential. The request must be submitted in writing to the custodian and:

- a. Identify the information for which confidential treatment is sought.
- b. Cite the legal basis that justifies confidential treatment.
- c. Give the reasons why the person would be aggrieved or adversely affected by disclosure of the information. The person may be required to provide any proof necessary to support these reasons.

4.6(2) The custodian shall notify the requester in writing of the granting or denial of the request and, if denied, the reasons therefor.

4.6(3) If the request is denied, the requester may apply to the director of transportation for reconsideration of the request.

This rule is intended to implement Iowa Code section 22.11.

761—4.7(22) Procedure by which additions, dissents, or objections may be entered into records. Except as otherwise provided by law, the person who is the subject of a record may have a written statement of additions, dissents or objections entered into that record. The statement shall be filed with the custodian. The statement must be dated and signed by the person who is the subject of the record and include the person's current address and telephone number. This rule does not authorize the person who is the subject of the record to alter the original record or to expand the official record of any agency proceeding.

This rule is intended to implement Iowa Code section 22.11.

761—4.8(22) Notice to suppliers of information. When the department requests a person to supply information about that person, the department shall notify the person of the use that will be made of the 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 or other rules of the department, on the written form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, orally, or by other appropriate means.

This rule is intended to implement Iowa Code section 22.11.

761—4.9(22) Confidential records. This rule describes the types of departmental information or records that are confidential. This rule is not exhaustive. A citation of the legal authority for confidentiality follows each description.

As related to particular types of confidential information or records, this rule also includes exceptions to confidentiality, the rights of certain persons to have access, and permissible disclosures.

Descriptions:

4.9(1) Hospital, medical and professional counselor records of the condition, diagnosis, care or treatment of present or former patients or advisees. (Iowa Code section 22.7)

- a. This category of records includes but is not limited to hospital, medical and professional counselor records of present or former departmental employees.
- b. Notwithstanding this subrule, State of Iowa Employers Work Injury Report forms are not confidential.
- c. The subject of a hospital, medical or professional counselor record has the right of access to it.

4.9(2) Trade secrets which are recognized and protected by law. (Iowa Code section 22.7)

- a. The person who furnished the trade secret information has the right of access to this information.
- b. Reserved.

4.9(3) Records which constitute attorney work product, attorney-client communications, or that are otherwise privileged. (Attorney work product is confidential under Iowa Code sections 22.7, 622.10 and 622.11, Iowa R. C. P. 1.503(3), Fed. R. Civ. P. 26(b)(3), and case law. Attorney-client communications are confidential under Iowa Code sections 622.10 and 622.11, the rules of evidence, the Code of Professional Responsibility, and case law.)

a. This category of records includes but is not limited to:

- (1) Investigations conducted in anticipation of tort claims or other litigation.
- (2) Records directly related to threatened litigation over title.

b. Reserved.

4.9(4) Peace officers' investigative reports, except where disclosure is required or authorized by the Iowa Code. However, the date, time, specific location, and immediate facts and circumstances surrounding a crime or incident are not confidential except in those unusual circumstances where disclosure would plainly and seriously jeopardize an investigation or would pose a clear and present danger to the safety of an individual. (Iowa Code section 22.7)

4.9(5) Reports to the department which, if released, would give advantage to competitors and serve no public purpose. (Iowa Code section 22.7)

a. Examples of records which could in the proper circumstances be determined to be within this category include but are not limited to:

(1) Financial reports filed by contractors for departmental use in determining their eligibility to bid on projects advertised for letting. This includes financial information from these reports that is stored on computer.

(2) Documents submitted by firms for departmental use in certifying their eligibility as disadvantaged business enterprises.

(3) Prequalification forms filed with the department under rule 761—20.8(307). This includes the selection committee's working papers; however, the final selection committee report is not confidential once it has been approved by the appropriate division director. Selection committee activities may also fall under subrule 4.9(20).

(4) Financial reports filed with the department for the purpose of seeking certificates of self-insurance under Iowa Code section 321A.34.

(5) Copies of agreements between sign owners and landowners filed with the department in support of the issuance of outdoor advertising permits.

(6) Copies of private contracts between railroads and shippers or other private parties.

(7) Barge terminal surveys which ask for shipping and financial information from barge companies.

b. The subject of the record has the right of access to it.

4.9(6) Criminal identification files, except for the records of current and prior arrests. (Iowa Code section 22.7)

a. The custodian may disseminate criminal identification data to a peace officer, a criminal justice agency, or a state or federal regulatory agency if the custodian is satisfied that the need to know and the intended use are reasonable.

b. The custodian shall also comply with Iowa Code chapter 692.

4.9(7) Personal information in confidential personnel records of present or former departmental employees. (Iowa Code section 22.7)

a. Submission by an employee of an employment application form shall constitute authorization for the release of a copy of the employee's complete personnel records to the selecting authority.

b. Confidential personnel information relating to a particular program shall be released to that agency or company which is administering the program.

c. The subject of a personnel record has the right of access to it.

4.9(8) Communications not required by law, rule or procedure that are made to the department by identified persons outside of government, to the extent that it could reasonably be believed that those persons would be discouraged from making the communications if they were made available for general public examination. (Iowa Code section 22.7)

a. This category of records includes but is not limited to exit interviews for voluntary terminations.

b. Exceptions to confidentiality:

- (1) A communication is not confidential if its author consents to its release.
- (2) Information in a communication that can be disclosed without identifying its author or enabling others to ascertain that identity is not confidential.
- (3) Information in a communication that indicates the date, time, specific location, and immediate facts and circumstances surrounding the occurrence of a crime or other illegal act is not confidential unless disclosure would plainly and seriously jeopardize a continuing investigation or would pose a clear and present danger to the safety of any person.

c. The author of a communication has the right of access to it.

4.9(9) Examinations, including but not limited to cognitive and psychological examinations for law enforcement officer candidates administered by or on behalf of a government body, to the extent that their disclosure could reasonably be believed by the lawful custodian to interfere with the accomplishment of the objectives for which they are administered. (Iowa Code section 22.7)

4.9(10) Information concerning the nature and location of an archaeological resource or site if, in the opinion of the state archaeologist, disclosure of the information will result in unreasonable risk of damage to or loss of the resource or site where the resource is located. (Iowa Code section 22.7)

4.9(11) Information concerning the nature and location of an ecologically sensitive resource or site if, in the opinion of the director of the department of natural resources after consultation with the state ecologist, disclosure of the information will result in unreasonable risk of damage to or loss of the resource or site where the resource is located. (Iowa Code section 22.7)

4.9(12) Those portions of the department's staff manuals, instructions or other statements issued which set forth criteria or guidelines to be used by departmental 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 enable law violators to avoid detection, facilitate disregard of requirements imposed by law, or give a clearly improper advantage to persons who are in an adverse position to the department. (Iowa Code sections 17A.2 and 17A.3)

4.9(13) The detailed minutes and tape recording of a closed session of the commission. However, if the closed session regards a real estate purchase, the minutes and tape recording shall be available for public inspection when the transaction discussed is completed. (Iowa Code section 21.5)

4.9(14) Vehicle accident reports submitted to the department by drivers and peace officers. (Iowa Code sections 321.266 and 321.271)

a. However, access shall be granted to those persons authorized by Iowa Code section 321.271.

b. Rescinded IAB 1/8/03, effective 2/12/03.

4.9(15) All information filed with the court for the purpose of securing a warrant for an arrest until the arrest has been made and the warrant has been returned. (Iowa Code section 804.29)

4.9(16) All information filed with the court for the purpose of securing a warrant for a search until the warrant has been executed and returned. (Iowa Code section 808.13)

4.9(17) Information obtained by the department from the examining of reports or records required to be filed or kept under the provisions of Iowa Code chapter 452A, except where disclosure is authorized by chapter 452A. (Iowa Code section 452A.63)

4.9(18) Sealed bids received prior to the time set for public opening of bids. (Iowa Code section 72.3)

4.9(19) Except as required by Iowa Code section 6B.45, the parcel file for a right-of-way acquisition until title has passed to the state and all contract and relocation claims have been paid. (Iowa Code section 22.7)

4.9(20) Those records which, if disclosed, would diminish competition or would give an improper advantage to persons who are in an adverse position to the department. These records shall be kept confidential until the transaction to which they relate is consummated. However, if disclosure would reveal information which would hinder future competition, the records shall be kept confidential. (Iowa Code sections 17A.2, 17A.3, 22.7 and 313.10, Iowa Code chapter 553, and 761—Chapter 20)

a. Examples of records which could, in the proper circumstances, be determined to be within this category include but are not limited to:

- (1) Detailed estimates of the cost of a proposed contract.
- (2) Economic analyses for determining pavement types.
- (3) Negotiations for a proposed contract.
- (4) Methodology for determining unfair bidding practices or bid rigging.
- (5) Price quotations solicited.
- (6) The value of points assigned to a bid rating formula prior to the time set for public opening of bids.

(7) Laboratory testing reports of suppliers' products. These may also be trade secrets. The subject of the report has the right of access to it.

b. Reserved.

4.9(21) Income tax forms or rental, income or expense statements furnished by relocatees as documentation for relocation assistance payments. (Iowa Code sections 22.7 and 422.20, 5 U.S.C. §§ 552 and 552a)

a. The subject of the form or statement has the right of access to it.

b. Reserved.

4.9(22) Audit reviews for determining EEO contract compliance. (Iowa Code section 22.7, 5 U.S.C. §§ 552 and 552a)

a. The subject of the audit review has the right of access to it.

b. Reserved.

4.9(23) Tax records made available to the department. (Iowa Code section 422.20)

4.9(24) Personal information in motor vehicle records. (Iowa Code section 321.11 and 18 U.S.C. § 2721 et seq.)

a. This information may be disclosed only as provided in Iowa Code section 321.11, 18 U.S.C. § 2721 et seq., and 761—Chapters 415, 610 and 611.

b. The subject of the personal information has the right of access to the information.

4.9(25) A report received by the department from a physician licensed under Iowa Code chapter 148, an advanced registered nurse practitioner licensed under Iowa Code chapter 152 and registered with the board of nursing, a physician assistant licensed under Iowa Code chapter 148C or an optometrist licensed under Iowa Code chapter 154 regarding a person who has been diagnosed as having a physical or mental condition which would render the person physically or mentally incompetent to operate a motor vehicle in a safe manner. (Iowa Code section 321.186)

4.9(26) Certain records regarding undercover driver's licenses issued to peace officers, as specified in 761—Chapter 625. (Iowa Code sections 22.7 and 321.189A)

a. The subject of the record and the head of the law enforcement agency employing the subject have the right of access to the record.

b. Reserved.

4.9(27) Records related to confidential plates issued for government vehicles. (Iowa Code section 321.19)

a. The head of the agency to which the vehicle is assigned has the right of access to the record.

b. Reserved.

4.9(28) Data processing software developed by the department. (Iowa Code section 22.7)

a. The custodian may provide, restrict or prohibit access to this software in accordance with Iowa Code section 22.3A.

b. Reserved.

4.9(29) Records containing information that would disclose, or might lead to the disclosure of, private keys used in a digital signature or other similar technologies as provided in Iowa Code chapter 554D, and records which, if disclosed, might jeopardize the security of an electronic transaction pursuant to Iowa Code chapter 554D. (Iowa Code section 22.7)

4.9(30) The portion of a record request that contains an Internet protocol number which identifies the computer from which a person requests a record. However, such record may be released with the express written consent of the requester. (Iowa Code section 22.7)

4.9(31) Certified transcripts of labor payrolls (also known as certified payroll records) filed by contractors for federal-aid construction contracts, in accordance with the following paragraphs. (Iowa Code section 22.7, 5 U.S.C. §§ 552 and 552a, 42 U.S.C. § 405)

a. The social security numbers in a certified payroll record are confidential. The record itself may be confidential if its release would give advantage to competitors and serve no public purpose.

b. The prime contractor and subcontractor, if applicable, that filed the record have the right of access to it.

c. Certified payroll records shall be released to the U.S. Department of Labor and Federal Highway Administration during investigations.

d. The custodian may release a certified payroll record with social security numbers withheld to representatives of the Iowa Labor Management Work Preservation Fund.

e. The custodian may release a certified payroll record with social security numbers withheld to persons outside the department other than the persons listed in paragraphs “*b*” to “*d*” according to the following procedure:

(1) The request for the record must be in writing.

(2) The custodian shall send a copy of the request by registered mail to the prime contractor. If the request is for subcontractor information, the custodian shall send copies of the request to both the subcontractor and prime contractor.

(3) The requested record shall not be released until 14 calendar days have expired from receipt of the request by the contractor(s). This gives the contractor(s) an opportunity to seek an injunction.

4.9(32) Information concerning an open or pending railroad accident investigation conducted on behalf of or in conjunction with the Federal Railroad Administration or National Transportation Safety Board to the extent necessary to prevent denial of funds, services or essential information from the United States government. (Iowa Code section 22.9)

4.9(33) All other information or records that by law are or may be confidential, with the following exceptions:

a. Records of the departmental library.

b. Reserved.

This rule is intended to implement Iowa Code chapters 22, 553 and 692; Iowa Code sections 6B.45, 17A.2, 17A.3, 21.5, 72.3, 313.10, 321.11, 321.19, 321.186, 321.189A, 321.266, 321.271, 422.20, 452A.63, 602.10112, 622.10, 622.11, 804.29 and 808.13; 5 U.S.C. §§ 552 and 552a; and 18 U.S.C. § 2721 et seq.

[ARC 0661C, IAB 4/3/13, effective 5/8/13]

761—4.10(22) Release of confidential records. Rescinded IAB 1/8/03, effective 2/12/03.

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CHAPTER 520
REGULATIONS APPLICABLE TO CARRIERS
[Prior to 6/3/87, Transportation Department[820]—(07,F) Ch 8]

761—520.1(321) Safety and hazardous materials regulations.

520.1(1) Regulations.

a. Motor carrier safety regulations. The Iowa department of transportation adopts the Federal Motor Carrier Safety Regulations, 49 CFR Parts 385 and 390-399 (October 1, 2012).

b. Hazardous materials regulations. The Iowa department of transportation adopts the Federal Hazardous Materials Regulations, 49 CFR Parts 107, 171-173, 177, 178, and 180 (October 1, 2012).

c. Copies of regulations. Copies of the federal regulations may be reviewed at the state law library or through the Internet at <http://www.fmcsa.dot.gov>.

520.1(2) Carriers subject to regulations.

a. Operators of commercial vehicles, as defined in Iowa Code section 321.1, are subject to the Federal Motor Carrier Safety Regulations adopted in this rule unless exempted under Iowa Code section 321.449.

b. Operators of vehicles transporting hazardous materials in commerce are subject to the Federal Hazardous Materials Regulations adopted in this rule unless exempted under Iowa Code section 321.450.

c. Operators of vehicles for hire, designed to transport 7 or more persons, but fewer than 16, including the driver, must comply with 49 CFR Part 395 of the Federal Motor Carrier Safety Regulations. In addition, operators of vehicles for hire designed to transport 7 or more persons, but fewer than 16, including the driver, are not exempt from logbook requirements afforded the 100-air-mile radius driver under 49 CFR 395.1(e). However, the provisions of 49 CFR Part 395 shall not apply to vehicles offered to the public for hire that are used principally in intracity operation and are regulated by local authorities.

520.1(3) Declaration of knowledge of regulations. Operators of commercial vehicles who are subject to the regulations adopted in this rule shall at the time of application for authority to operate in Iowa or upon receipt of their Iowa registration declare knowledge of the Federal Motor Carrier Safety Regulations and Federal Hazardous Materials Regulations adopted in this rule.

This rule is intended to implement Iowa Code sections 321.1, 321.449 and 321.450.

[ARC 7750B, IAB 5/6/09, effective 6/10/09; ARC 8720B, IAB 5/5/10, effective 6/9/10; ARC 9493B, IAB 5/4/11, effective 6/8/11; ARC 0034C, IAB 3/7/12, effective 4/11/12; ARC 0660C, IAB 4/3/13, effective 5/8/13]

761—520.2(321) Definitions. The following definitions apply to the regulations adopted in rule 761—520.1(321):

“Any requirements which impose any restrictions upon a person” as used in Iowa Code section 321.449(6) means the requirements in 49 CFR Parts 391 and 395.

“Driver age qualifications” as used in Iowa Code section 321.449(3) means the age qualifications in 49 CFR 391.11(b)(1).

“Driver qualifications” as used in Iowa Code section 321.449(2) means the driver qualifications in 49 CFR Part 391.

“Farm customer” as used in Iowa Code section 321.450, unnumbered paragraph 3, means a retail consumer residing on a farm or in a rural area or city with a population of 3000 or less.

“Gasoline” as used in Iowa Code section 321.450, first unnumbered paragraph, means leaded gasolines, no-lead gasolines, ethanol and ethanol-blended gasolines, aviation gasolines, number 1 and number 2 fuel oils, diesel fuels, aviation jet fuels and kerosene.

“Hours of service” as used in Iowa Code section 321.449(2) means the hours of service requirements in 49 CFR Part 395.

“Record-keeping requirements” as used in Iowa Code section 321.449(2) means the record-keeping requirements in 49 CFR Part 395.

“Rules adopted under this section concerning physical and medical qualifications” as used in Iowa Code section 321.449(5) and Iowa Code section 321.450, unnumbered paragraph 2, means the regulations in 49 CFR 391.11(b)(4) and 49 CFR Part 391, Subpart E.

“Rules adopted under this section for a driver of a commercial vehicle” as used in Iowa Code section 321.449(4) means the regulations in 49 CFR Parts 391 and 395.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

761—520.3(321) Motor carrier safety regulations exemptions.

520.3(1) The following intrastate vehicle operations are exempt from the motor carrier safety regulations concerning inspection in 49 CFR Part 396.17 as adopted in rule 761—520.1(321):

- a. Implements of husbandry including nurse tanks as defined in Iowa Code section 321.1.
- b. Special mobile equipment (SME) as defined in Iowa Code section 321.1.
- c. Unregistered farm trailers as defined in 761—subrule 400.1(3), pursuant to Iowa Code section 321.123.
- d. Motor vehicles registered for a gross weight of five tons or less when used by retail dealers or their employees to deliver hazardous materials, fertilizers, petroleum products and pesticides to farm customers.

520.3(2) Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.123, 321.449 and 321.450.

761—520.4(321) Hazardous materials exemptions. These exemptions apply to the regulations adopted in rule 761—520.1(321):

520.4(1) Pursuant to Iowa Code section 321.450, unnumbered paragraph 3, “retail dealers of fertilizers, petroleum products, and pesticides and their employees while delivering fertilizers, petroleum products and pesticides to farm customers within a 100-air-mile radius of their retail place of business” are exempt from 49 CFR 177.804; and, pursuant to Iowa Code section 321.449(4), they are exempt from 49 CFR Parts 391 and 395. However, pursuant to Iowa Code section 321.449, the retail dealers and their employees under the specified conditions are subject to the regulations in 49 CFR Parts 390, 392, 393, 396 and 397.

520.4(2) Rescinded IAB 3/10/99, effective 4/14/99.

This rule is intended to implement Iowa Code section 321.450.

761—520.5(321) Safety fitness.

520.5(1) *New motor carrier safety audits.* Peace officers in the office of motor vehicle enforcement of the Iowa department of transportation shall perform safety audits of new motor carriers and shall have the authority to enter a motor carrier’s place of business for the purpose of performing these audits. These audits shall be performed in compliance with 49 CFR Part 385 and shall be completed within 18 months from the day the motor carrier commences business.

520.5(2) *Motor carrier compliance reviews.* Peace officers in the office of motor vehicle enforcement of the Iowa department of transportation shall perform compliance reviews of motor carriers and shall have the authority to enter a motor carrier’s place of business for the purpose of performing these compliance reviews. These compliance reviews shall be performed in compliance with 49 CFR Part 385.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

761—520.6(321) Out-of-service order. A person shall not operate a commercial vehicle or transport hazardous material in violation of an out-of-service order issued by an Iowa peace officer. An out-of-service order for noncompliance shall be issued when either the vehicle operator is not qualified to operate the vehicle or the vehicle is unsafe to be operated until required repairs are made. The out-of-service order shall be consistent with the North American Uniform Out-of-Service Criteria.

This rule is intended to implement Iowa Code sections 321.3, 321.208A, 321.449, and 321.450.

761—520.7(321) Driver’s statement. A “driver” as used in Iowa Code section 321.449(5) and Iowa Code section 321.450, unnumbered paragraph 2, shall carry at all times a notarized statement of employment. The statement shall include the following:

1. The driver’s name, address and social security number;

2. The name, address and telephone number of the driver's pre-July 29, 1996, employer;
 3. A statement, signed by the pre-July 29, 1996, employer or the employer's authorized representative, that the driver was employed to operate a commercial vehicle only in Iowa; and
 4. A statement showing the driver's physical or medical condition existed prior to July 29, 1996.
- This rule is intended to implement Iowa Code sections 321.449 and 321.450.

761—520.8(321) Agricultural operations. The provisions of 49 CFR Part 395.3 shall not apply to drivers transporting agricultural commodities or farm supplies for agricultural purposes in Iowa if such transportation:

1. Is limited to an area within a 100-air-mile radius from the source of the commodities or the distribution point from the farm supplies, and
2. Is conducted only during the time frames of March 15 through June 30 and October 4 through December 14.

This rule is intended to implement Iowa Code sections 321.449 and 321.450.

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¹ Effective date of 520.1(1)“a” and “b”; rescission of 520.1(2)“b”; and 520.3 delayed until adjournment of the 1993 Regular Session of the General Assembly by the Administrative Rules Review Committee at its meeting held October 14, 1992; delay lifted by the Committee November 10, 1992.

DRIVER LICENSES
CHAPTER 600
GENERAL INFORMATION

[Prior to 6/3/87, Transportation Department[820]—(07,C)Ch 13]

761—600.1(321) Definitions. The definitions in Iowa Code section 321.1 and the following definitions apply to the rules in 761—Chapters 600 to 699.

“Director of the office of driver services” includes the office director’s designee.

“License” means “driver’s license” as defined in Iowa Code subsection 321.1(20A) unless the context otherwise requires.

“Medical report” means a report from a qualified medical professional attesting to a person’s physical or mental capability to operate a motor vehicle safely. The report should be submitted on Form 430031, “Medical Report.” In lieu of Form 430031, a report signed by a qualified medical professional on the qualified medical professional’s letterhead may be accepted if it contains all the information specified on Form 430031.

“Qualified medical professional” means a person licensed as a physician under Iowa Code chapter 148, a person licensed as an advanced registered nurse practitioner under Iowa Code chapter 152 and registered with the board of nursing, or a person licensed as a physician assistant under Iowa Code chapter 148C, when practicing within the scope of the person’s professional licensure.

This rule is intended to implement Iowa Code section 321.1.

[ARC 0661C, IAB 4/3/13, effective 5/8/13]

761—600.2(17A) Information and location. Applications, forms and information concerning driver’s licensing are available at any driver’s license examination station. Assistance is also available by mail from the Office of Driver Services, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (800)532-1121; or by facsimile at (515)237-3071.

This rule is intended to implement Iowa Code section 17A.3.

761—600.3(321) Persons exempt.

600.3(1) Persons listed in Iowa Code section 321.176 are exempt from driver’s licensing requirements.

600.3(2) “Nearby” in Iowa Code subsection 321.176(2) shall mean a distance of not more than two miles.

This rule is intended to implement Iowa Code section 321.176.

761—600.4(252J,261,321) Persons not to be licensed.

600.4(1) The department shall not knowingly issue a license to any person who is ineligible for licensing.

600.4(2) The department shall not knowingly license any person who is unable to operate a motor vehicle safely because of physical or mental disability until that person has submitted a medical report stating that the person is physically and mentally capable of operating a vehicle safely.

600.4(3) The department shall not knowingly license any person who has been specifically adjudged incompetent, pursuant to Iowa Code chapter 229, on or after January 1, 1976, including anyone admitted to a mental health facility prior to that date and not released until after, until it receives specific adjudication that the person is competent. A medical report stating that the person is physically qualified to operate a motor vehicle safely shall also be required.

600.4(4) The department shall not knowingly license any person who suffers from syncope of any cause, any type of periodic or episodic loss of consciousness, or any paroxysmal disturbances of consciousness, including but not limited to epilepsy, until that person has not had an episode of loss of consciousness or loss of voluntary control for six months, and then only upon receipt of a medical report favorable toward licensing.

a. If a medical report indicates a pattern of only syncope, the department may license without a six-month episode-free period after favorable recommendation by the medical advisory board.

b. If a medical report indicates a pattern of such episodes only when the person is asleep or is sequestered for sleep, the department may license without a six-month episode-free period.

c. If an episode occurs when medications are withdrawn by a qualified medical professional, but the person is episode-free when placed back on medications, the department may license without a six-month episode-free period with a favorable recommendation from a neurologist.

d. If a medical report indicates the person experienced a single nonrecurring episode, the cause has been identified, and the qualified medical professional is not treating the person for the episode and believes it is unlikely to recur, the department may license without the six-month episode-free period with a favorable recommendation from a qualified medical professional.

600.4(5) The department shall not license any person who must wear bioptic telescopic lenses to meet the visual acuity standard required for a license.

600.4(6) When a medical report is required, a license shall be issued only if the report indicates that the person is qualified to operate a motor vehicle safely. The department may submit the report to the medical advisory board for an additional opinion.

600.4(7) When the department receives evidence that an Iowa licensed driver has been adjudged incompetent or is not physically or mentally qualified to operate a motor vehicle safely, the department shall suspend the license for incapability, as explained in rule 761—615.14(321), or shall deny further licensing, as explained in rule 761—615.4(321).

600.4(8) The department shall not knowingly issue a license to a person who is the named individual on a certificate of noncompliance that has been received from the child support recovery unit, until the department receives a withdrawal of the certificate of noncompliance or unless an application has been filed pursuant to Iowa Code section 252J.9.

600.4(9) The department shall not knowingly issue a license to a person who is the named individual on a certificate of noncompliance that has been received from the college student aid commission, until the department receives a withdrawal of the certificate of noncompliance or unless an application has been filed pursuant to Iowa Code section 261.127.

This rule is intended to implement Iowa Code sections 252J.8, 252J.9, 261.126, 261.127, 321.13, 321.177, 321.210, and 321.212.

[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 0661C, IAB 4/3/13, effective 5/8/13]

761—600.5 to 600.11 Reserved.

761—600.12(321) Private and commercial driver education schools. Rescinded IAB 3/31/04, effective 5/5/04.

761—600.13(321) Behind-the-wheel instructor's certification. Rescinded IAB 3/31/04, effective 5/5/04.

761—600.14(321) Payment of fees. Rescinded IAB 3/31/04, effective 5/5/04.

761—600.15 Reserved.

761—600.16(321) Seat belt exemptions.

600.16(1) A person who is unable to wear a safety belt or safety harness for physical or medical reasons may obtain a form to be signed by the person's health care provider licensed under Iowa Code chapter 148 or 151. Form No. 432017, "Iowa Medical Safety Belt Exemption," is available from the office of driver services at the address in rule 761—600.2(17A).

600.16(2) Iowa Code section 321.445, subsections 1 and 2, shall not apply to the front seats and front seat passengers of motor vehicles owned, leased, rented or primarily used by a person with a physical disability who uses a collapsible wheelchair.

This rule is intended to implement Iowa Code section 321.445.

[ARC 9991B, IAB 2/8/12, effective 3/14/12]

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[◇] Two or more ARCs

¹ Effective date of 761—600.13(321) delayed 70 days by the Administrative Rules Review Committee at its meeting held December 9, 1998. At its meeting held January 5, 1999, the Committee delayed the effective date until adjournment of the 1999 Session of the General Assembly.

CHAPTER 605
LICENSE ISSUANCE

761—605.1(321) Scope. This chapter of rules applies to the issuance of all Iowa driver's licenses. Additional information on the issuance of a commercial driver's license or a commercial driver's instruction permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code section 321.174.

761—605.2(321) Contents of license. In addition to the information specified in Iowa Code subsection 321.189(2), the following information shall be shown on a driver's license.

605.2(1) Name. The licensee's full legal name shall be listed as established according to 761—subrule 601.5(1) and 761—subrule 601.5(5) and shall conform to the requirements of 761—subrule 601.1(2).

605.2(2) Current residential address. The licensee's current residential address shall be listed as established according to the requirements of 761—subrule 601.5(3).

605.2(3) Physical description. The physical description of the licensee on the face of the driver's license shall include:

a. The licensee's eye color using these abbreviations: Blk-black, Blu-blue, Bro-brown, Gry-gray, Grn-green, Haz-hazel, and Pnk-pink.

b. The licensee's height in inches.

605.2(4) Date of birth. The licensee's date of birth shall be listed as established according to 761—subrule 601.5(1) and 761—subrule 601.5(6).

605.2(5) Sex. The licensee's sex designation shall be listed as established according to the requirements of 761—subrule 601.5(7).

605.2(6) REAL ID markings.

a. A driver's license that is issued as a REAL ID license as defined in 761—601.7(321) shall include a security marking as required by 6 CFR 37.17(n).

b. Beginning January 15, 2013, a driver's license that is not issued as a REAL ID license as defined in 761—601.7(321) may be marked as required by 6 CFR 37.71 and any subsequent guidance issued by the U.S. Department of Homeland Security.

c. A driver's license issued to a foreign national with temporary lawful status shall include the following statement on the face of the license: "limited term."

This rule is intended to implement Iowa Code section 321.189, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12]

761—605.3(321) License class. The driver's license class shall be coded on the face of the driver's license using these codes:

Class A—commercial driver's license

Class B—commercial driver's license

Class C—commercial driver's license

Class C—noncommercial driver's license

Class D—noncommercial driver's license, chauffeur

Class M—noncommercial driver's license, motorcycle only

This rule is intended to implement Iowa Code section 321.189.

761—605.4(321) Endorsements. The endorsements shall be coded on the face of the driver's license and explained in text on the back of the driver's license.

605.4(1) For a commercial driver's license. The following endorsements may be added to a Class A, B or C commercial driver's license using these letter codes:

H—Hazardous material

P—Passenger

N—Tank

X—Hazardous material and tank

T—Double/triple trailers

S—School bus

605.4(2) *For a Class D driver's license (chauffeur).* The following endorsements may be added to a Class D driver's license using these number codes:

1—Truck-tractor semitrailer combination

2—Vehicle with 16,001 pounds gross vehicle weight rating or more. Not valid for truck-tractor semitrailer combination

3—Passenger vehicle less than 16-passenger design

605.4(3) *Motorcycle endorsement.* A motorcycle endorsement may be added to any driver's license that permits unaccompanied driving, other than a Class M driver's license or a motorized bicycle license, using the following letter code:

L—Motorcycle

This rule is intended to implement Iowa Code section 321.189.

761—605.5(321) Restrictions. Restrictions shall be coded on the face of the driver's license and explained in text on the back of the driver's license.

605.5(1) *For all licenses.* The following restrictions may apply to any driver's license:

B—Corrective lenses required

C—Mechanical aid (as detailed in the restriction on the back of the card)

D—Prosthetic aid (as detailed in the restriction on the back of the card)

E—Automatic transmission

F—Left and right outside rearview mirrors

G—No driving when headlights required

H—Temporary restricted license or permit (work permit)

I—Ignition interlock required

J—Restrictions on the back of card

S—SR required (proof of financial responsibility for the future)

T—Medical report required at renewal

U—Not valid for 2-wheel vehicle

W—Restricted commercial driver's license (CDL)

Y—Intermediate license

605.5(2) *For a noncommercial driver's license.* The following restrictions apply only to a noncommercial driver's license:

P—Special instruction permit

Q—No interstate or freeway driving

605.5(3) *For a commercial driver's license.* The following restrictions apply only to a commercial driver's license:

K—Commercial driver's license intrastate only

L—Vehicle without air brakes

M—Except Class A bus

N—Except Class A and Class B bus

O—Except tractor-trailer

V—Medical Variance document required

605.5(4) *Special licenses.* A numbered restriction will designate a special driver's license using these codes:

1—Motorcycle instruction permit

2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)

3—Commercial driver's instruction permit

4—Chauffeur's instruction permit

5—Motorized bicycle license

6—Minor's restricted license

7—Minor's school license

605.5(5) Additional information.

a. Reexamination or report. The department may issue a restriction requiring a person to reappear at a specified time for examination. The department may require a medical report to be submitted. The department shall send Form 430029 as a reminder to appear.

b. Loss of consciousness or voluntary control.

(1) If a person is licensed pursuant to 761—subrule 600.4(4), the department shall issue the first driver's license with a restriction stating: "Medical report to be furnished at the end of six months."

(2) If this medical report shows that the person has been free of an episode of loss of consciousness or voluntary control since the previous medical report and the report recommends licensing, the department shall issue a duplicate driver's license with a restriction stating: "Medical report required at renewal." At each renewal accompanied by a favorable medical report, the department shall issue a two-year driver's license with the same restriction.

(3) If the latest medical report indicates the person experienced only a single nonrecurring episode, the cause has been identified, and the qualified medical professional is not treating or has not treated the person for the episode and believes it is unlikely to recur, the department may waive the medical report requirement upon receipt of a favorable recommendation from a qualified medical professional.

(4) The department may remove the medical report requirement and issue a full-term driver's license if recommended by a qualified medical professional and if the latest medical information on file with the department indicates the person has not had an episode of loss of consciousness or voluntary control and has not been prescribed medications to control such episodes during the 24-month period immediately preceding application for a license.

(5) The department may remove the medical report requirement and issue a full-term driver's license if recommended by a qualified medical professional and if the latest medical information on file with the department indicates the person has not had an episode of loss of consciousness or voluntary control during the 10-year period immediately preceding application for a license.

c. Financial responsibility. When a person is required under Iowa Code chapter 321A to have future proof of financial responsibility on file, the license restriction will read: "SR required." The license shall be valid only for the operation of motor vehicles covered by the class of license issued and by the proof of financial responsibility filed.

d. Vision restriction. Restrictions relating to vision are addressed in 761—Chapter 604.

This rule is intended to implement Iowa Code chapter 321A and sections 321.178, 321.180, 321.180A, 321.180B, 321.189, 321.193, 321.194, 321.215, 321J.4, and 321J.20.

[ARC 9991B, IAB 2/8/12, effective 3/14/12; ARC 0661C, IAB 4/3/13, effective 5/8/13]

761—605.6(321) License term for temporary foreign national. A driver's license issued to a person who is a foreign national with temporary lawful status shall be issued only for the length of time the person is authorized to be present as verified by the department, not to exceed two years. However, if the person's lawful status as verified by the department has no expiration date, the driver's license shall be issued for a period of no longer than one year.

This rule is intended to implement Iowa Code section 321.196, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12]

761—605.7(321L) Handicapped designation. Rescinded IAB 2/11/98, effective 3/18/98.

761—605.8 Reserved.

761—605.9(321) Fees for driver's licenses. Fees for driver's licenses are specified in Iowa Code section 321.191. A license fee may be paid by cash, check, credit card, debit card or money order. If payment is by check, the following requirements apply:

605.9(1) The check shall be for the exact amount of the fee and shall be payable to: Treasurer, State of Iowa. An exception may be made when a traveler's check is presented.

605.9(2) One check may be used to pay fees for several persons, such as members of a family or employees of a business firm. One check may pay all fees involved, such as the license fee and the reinstatement fee.

This rule is intended to implement Iowa Code section 321.191.
[ARC 9991B, IAB 2/8/12, effective 3/14/12]

761—605.10(321) Waiver or refund of license fees. Rescinded IAB 2/8/12, effective 3/14/12.

761—605.11(321) Duplicate license.

605.11(1) *Lost, stolen or destroyed license.* To replace a valid license that is lost, stolen or destroyed, the licensee shall submit Form 430052 and shall comply with the requirements of 761—601.5(321). The replacement fee is \$3.

605.11(2) *Voluntary replacement.* The department shall issue a duplicate of a valid license to an eligible licensee if the license is surrendered to the department and the \$1 voluntary replacement fee is paid. Voluntary replacement includes but is not limited to:

- a. Replacement of a damaged license.
- b. Replacement to change the current residential address on a license. The licensee shall comply with the requirements of 761—subrule 601.5(3) to establish a change of current residential address.
- c. Replacement to change the name on a license. The licensee shall comply with the requirements of 761—subrule 601.5(5) to establish a name change.
- d. Replacement to change the date of birth on a license. The licensee shall comply with the requirements of 761—subrule 601.5(6) to establish a change of date of birth.
- e. Replacement to change the sex designation on a license. The licensee shall comply with the requirements of 761—subrule 601.5(7) to establish a change of sex designation.
- f. Issuance of a license without the words “under 21” to a licensee who is 21 years of age or older.
- g. Issuance of a license without the words “under 18” to a licensee who is 18 years of age or older. (If the licensee is under 21 years of age, the words “under 21” will replace the words “under 18.”)
- h. Issuance of a noncommercial driver’s license to an eligible person who has been disqualified from operating a commercial motor vehicle.
- i. Replacement of a valid license before its expiration date to obtain a license that may be accepted for federal identification purposes under 6 CFR Part 37 (a REAL ID license). The licensee shall comply with the requirements of 761—601.5(321) to obtain a REAL ID license.

This rule is intended to implement Iowa Code sections 321.189, 321.195 and 321.208, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 0347C, IAB 10/3/12, effective 11/7/12]

761—605.12(321) Address changes.

605.12(1) A licensee shall notify the department of a change in the licensee’s mailing address within 30 days of the change. Notice shall be given by:

- a. Submitting the address change in writing to the office of driver services, or
- b. Appearing in person to change the mailing address at any driver’s license examination station.

605.12(2) Parents or legal guardians may provide written notice of a mailing address change on behalf of their minor children.

605.12(3) The department may use U.S. Postal Service address information to update its address records.

This rule is intended to implement Iowa Code sections 321.182 and 321.184.

761—605.13 and 605.14 Reserved.

761—605.15(321) License extension.

605.15(1) *Six-month extension.* An Iowa resident may apply for a six-month extension of a license if the resident:

- a. Has a valid license,

- b. Is eligible for further licensing, and
- c. Is temporarily absent from Iowa or is temporarily incapacitated at the time for renewal.

605.15(2) Procedure. The licensee shall apply for an extension by submitting Form 430027 to the department. The form may be obtained from and submitted to a driver's license examination station. The licensee may also apply by letter to the address in 761—600.2(17A).

a. A six-month extension shall be added to the expiration date on the license. When the licensee appears to renew the license, the expiration date of the renewed license will be computed from the expiration date of the original license, notwithstanding the extension.

b. The department shall allow only two six-month extensions.

This rule is intended to implement Iowa Code section 321.196.

761—605.16(321) Military extension.

605.16(1) Form 430028. A person who qualifies for a military extension of a valid license should request Form 430028 from the department and carry it with the license for verification to peace officers. Form 430028 explains the provisions of Iowa Code section 321.198 regarding military extensions.

605.16(2) Request for retention of record. A person with a military extension may request that the department retain the record of license issuance for the duration of the extension or reenter the record if it has been removed from department records. The request may be made by letter or by using Form 430081. The letter or Form 430081 shall be signed by the person's commanding officer to verify the military service and shall be submitted to the department at the address in 761—600.2(17A).

605.16(3) Renewal of license after military extension. When an applicant renews a license after a military extension, the department may require the applicant to provide documentation of both the military service and the date of separation from military service.

605.16(4) Reinstatement after sanction. A person with a military extension whose license has been canceled, suspended or revoked shall comply with the requirements of 761—615.40(321) to reinstate the license.

This rule is intended to implement Iowa Code section 321.198.

761—605.17 to 605.19 Reserved.

761—605.20(321) Fee adjustment for upgrading license. The fee for upgrading a driver's license shall be computed on a full-year basis. The fee is charged for each year or part of a year between the date of the change and the expiration date on the license.

605.20(1) The fee to upgrade a driver's license from one class to another is determined by computing the difference between the current license fee and the new license fee as follows:

- a. Converting noncommercial Class C to Class D—\$4 per year of new license validity.
- b. Converting Class M to Class D with a motorcycle endorsement—\$4 per year of new license validity.
- c. Converting Class M to noncommercial Class C with a motorcycle endorsement—\$1 one-time fee.

605.20(2) The fee to add a privilege to a driver's license is computed per year of new license validity as follows:

Noncommercial Class C (full privileges from a restricted Class C)	\$4 per year
Motorized bicycle	\$4 per year
Minor's restricted license	\$4 per year
Minor's school license	\$4 per year
Motorcycle instruction permit	\$1 per year
Motorcycle endorsement	\$1 per year

This rule is intended to implement Iowa Code sections 321.189 and 321.191.

761—605.21 to 605.24 Reserved.

761—605.25(321) License renewal.

605.25(1) A licensee who wishes to renew a driver's license shall apply to the department and, if required, pass the appropriate examination.

605.25(2) A valid license may be renewed 30 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier.

605.25(3) A valid license may be renewed within 60 days after the expiration date, unless otherwise specified.

605.25(4) If the licensee's current residential address, name, date of birth, or sex designation has changed since the previous license was issued, the licensee shall comply with the following:

a. Current residential address. The licensee shall comply with the requirements of 761—subrule 601.5(3) to establish a change of current residential address.

b. Name. The licensee shall comply with the requirements of 761—subrule 601.5(5) to establish a name change.

c. Date of birth. The licensee shall comply with the requirements of 761—subrule 601.5(6) to establish a change of date of birth.

d. Sex designation. The licensee shall comply with the requirements of 761—subrule 601.5(7) to establish a change of sex designation.

605.25(5) A licensee who has not previously been issued a license that may be accepted for federal identification purposes under 6 CFR Part 37 (a REAL ID license) and wishes to obtain a REAL ID license upon renewal must comply with the requirements of 761—601.5(321) to obtain a REAL ID license upon renewal.

605.25(6) A licensee who is a foreign national with temporary lawful status must provide documentation of lawful status as required by 761—subrule 601.5(4) at each renewal.

This rule is intended to implement Iowa Code sections 321.186 and 321.196, the REAL ID Act of 2005 (49 U.S.C. Section 30301 note), and 6 CFR Part 37.

[ARC 0347C, IAB 10/3/12, effective 11/7/12]

761—605.26(321) License renewal by mail. Rescinded IAB 3/20/02, effective 4/24/02.

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¹ Effective date of December 29, 1993, for 761—605.26(2) "a" and "d," delayed 70 days by the Administrative Rules Review Committee at its meeting held December 15, 1993; delay lifted by this Committee on January 5, 1994, effective January 6, 1994.