The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

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

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.
INSTRUCTIONS
FOR UPDATING THE
IOWA ADMINISTRATIVE CODE

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

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

Real Estate Appraiser Examining Board[193F]
Replace Analysis
Replace Chapter 1
Replace Chapters 5 and 6
Replace Chapter 11

Education Department[281]
Replace Analysis
Replace Chapter 25
Remove Chapter 66 and Insert Reserved Chapter 66

Human Services Department[441]
Replace Analysis
Replace Chapter 7
Replace Chapter 13
Replace Chapter 22
Replace Chapter 57
Replace Chapters 77 and 78
Replace Chapter 81
Remove Chapters 161 and 162
Insert Reserved Chapters 161 and 162
Remove Chapter 164 and Reserved Chapter 165
Insert Reserved Chapters 164 and 165

Professional Licensure Division[645]
Replace Chapters 21 and 22
Replace Chapters 60 and 61
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CHAPTER 1
ORGANIZATION AND ADMINISTRATION

[Prior to 2/20/02, see 193F—Chapters 2, 9 and 11]

193F—1.1(543D) Description.

1.1(1) The purpose of the real estate appraiser examining board is to administer and enforce the provisions of Iowa Code chapter 543D (Iowa Voluntary Appraisal Standards and Appraiser Certification Law of 1989) with regard to the appraisal of real property in the state of Iowa, including the examination of candidates and issuance of certificates and registrations; investigation of alleged violations and infractions of the appraisal standards and appraiser certification law; and the disciplining of appraisers. The importance of the role of the appraiser places ethical and professional standards on those who serve in this capacity. To this end, the board has promulgated these rules and has adopted the Uniform Standards of Professional Appraisal Practice (USPAP) to clarify the board’s intent and procedures and to promote and maintain a high level of public trust in professional appraisal practice.

1.1(2) All official communications, including submissions and requests, should be addressed to the board at its official address, 200 E. Grand Avenue, Suite 350, Des Moines, Iowa 50309.

1.1(3) All board action under Iowa Code chapter 543D and 193F—Chapter 17 shall be taken under the supervision of the superintendent, as provided in Iowa Code section 543D.23 and the implementing rules set forth herein.

[ARC 1467C, IAB 5/28/14; effective 7/2/14; ARC 2808C, IAB 11/9/16, effective 1/1/17; ARC 4379C, IAB 3/27/19, effective 5/1/19]

193F—1.2(543D) Administrative authority.

1.2(1) The superintendent is vested with authority to review, approve, modify, or reject all board action pursuant to Iowa Code chapter 543D and 193F—Chapter 17. The superintendent may exercise all authority conferred upon the board and shall have access to all records and information to which the board has access. In supervising the board, the superintendent shall independently evaluate the substantive merits of recommended or proposed board actions which may be anticompetitive.

1.2(2) In performing its duties and in exercising its authority under Iowa Code chapter 543D and 193F—Chapter 17, the board may take action without preclearance by the superintendent if the action is ministerial or nondiscretionary. As used in this chapter, “ministerial or nondiscretionary” shall include any action expressly required by state or federal law, rule, or regulation; by the AQB; or by the appraisal subcommittee. The board may, for example, grant or deny an application for initial or reciprocal certification as a real estate appraiser, an application for registration as an associate real estate appraiser, or an application for a temporary practice permit by an out-of-state appraiser, on any ground expressly required by state or federal law, rule, or regulation; by the AQB; or by the appraisal subcommittee.

1.2(3) Prior to taking discretionary action under Iowa Code chapter 543D and 193F—Chapter 17, the board shall secure approval of the superintendent if the proposed action is or may be anticompetitive, as provided in 193F—Chapter 17. As used in this chapter, “discretionary” shall include any action that is authorized but not expressly required by state or federal law, rule, or regulation; by the AQB; or by the appraisal subcommittee. Examples of discretionary action include orders in response to petitions for rule making, declaratory orders, or waivers from rules, rule making, disciplinary proceedings against licensees, administrative proceedings against unlicensed persons, or any action commenced in the district court.

1.2(4) Determining whether any particular action is or may be anticompetitive is necessarily a fact-based inquiry dependent on a number of factors, including potential impact on the market or restraint of trade. With respect to disciplinary actions, for instance, a proceeding against a single licensee for violating appraisal standards would not have an impact on the broader market and would accordingly not be an anticompetitive action. Commencement of disciplinary proceedings which affect all or a substantial subset of appraisers may have a significant market impact. When in doubt as to whether a proposed discretionary action is or may be anticompetitive, the board may submit the proposed action through the preclearance procedures outlined in 193F—Chapter 17.
1.2(5) A person aggrieved by any final action of the board taken under Iowa Code chapter 543D or 193F—Chapter 17 may appeal that action to the superintendent within 20 days of the date the board issues the action.

a. The appeal process applies whether the board action at issue was ministerial or nondiscretionary, or discretionary, and whether the proposed action was or was not submitted through a preclearance process before the superintendent.

b. No person aggrieved by a final action of the board may seek judicial review of that action without first appealing the action to the superintendent, as more fully described in 193F—Chapter 17.

c. Records, filings, and requests for public information. Final board action, regardless of whether such board action is ministerial, nondiscretionary, or discretionary, shall be immediately effective when issued by the board but is subject to review or appeal to the superintendent as permitted by and in accordance with 193F—Chapter 17. If a timely review is initiated or a timely appeal is taken, the effectiveness of such final board action shall be delayed during the pendency of such review or appeal.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 2808C, IAB 11/9/16, effective 1/1/17; ARC 4379C, IAB 3/27/19, effective 5/1/19; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5484C, IAB 2/24/21, effective 3/31/21]

193F—1.3(543D) Annual meeting. The annual meeting of the board shall be the first meeting scheduled after April 30. At this time, the chairperson and vice chairperson shall be elected to serve until their successors are elected.

[ARC 1467C, IAB 5/28/14, effective 7/2/14]

193F—1.4(543D) Other meetings. In addition to the annual meeting, and in addition to other meetings, the time and place of which may be fixed by resolution of the board, any meeting may be called by the chairperson of the board or by joint call of a majority of its members.

[ARC 1467C, IAB 5/28/14, effective 7/2/14]

193F—1.5(543D) Executive officer’s duties.

1.5(1) The executive officer shall cause complete records to be kept of applications for examination and registration, certificates and permits granted, and all necessary information in regard thereto.

1.5(2) The executive officer shall determine when the legal requirements for certification and registration have been satisfied with regard to issuance of certificates or registrations, and the executive officer shall submit to the board any questionable application.

1.5(3) The executive officer shall keep accurate minutes of the meetings of the board. The executive officer shall keep a list of the names of persons issued certificates as certified general real property appraisers, certified residential real property appraisers and associate real property appraisers.

193F—1.6(543D) Records, filings, and requests for public information. Unless otherwise specified by the rules of the department of commerce, the board is the principal custodian of its own agency orders, statements of law or policy issued by the board, legal documents, and other public documents on file with the board.

1.6(1) Any person may examine public records promulgated or maintained by the board at its office during regular business hours as specified in 193F—Chapter 25.

1.6(2) Records, documents and other information may be gathered, stored, and available in electronic format. Information, various forms, documents, and the law and rules may be reviewed or obtained anytime by the public from the board’s Internet website located at idob.state.ia.us/reap.

1.6(3) Deadlines. Unless the context requires otherwise, such as is the case for timely and late renewal of a registration or certificate, any deadline for filing a document shall be extended to the next working day when the deadline falls on a Saturday, Sunday, or official state holiday.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 4379C, IAB 3/27/19, effective 5/1/19; ARC 6170C, IAB 2/9/22, effective 3/16/22]

193F—1.7(543D) Adoption, amendment or repeal of administrative rules.

1.7(1) The board shall adopt, amend or repeal its administrative rules in accordance with the provisions of Iowa Code section 17A.4. Prior to the adoption, amendment or repeal of any rule of the board, any interested person, as described in Iowa Code section 17A.4(1) “b,” may submit any
data, views, or arguments in writing concerning such rule or may request to make an oral presentation concerning such rule. Such written comments or requests to make oral presentations shall be filed with the board at its official address and shall clearly state:

   a. The name, address, and telephone number of the person or agency authoring the comment or request;
   b. The number and title of the proposed rule, which is the subject of the comment or request as given in the Notice of Intended Action;
   c. The general content of the oral presentation. A separate comment or request to make an oral presentation shall be made for each proposed rule to which remarks are to be asserted.

1.7(2) The receipt and acceptance for consideration of written comments and requests to make oral presentations shall be acknowledged by the board.

1.7(3) Written comments received after the deadline set forth in the Notice of Intended Action may be accepted by the board although their consideration is not assured. Requests to make an oral presentation received after the deadline shall not be accepted and shall be returned to the requester.

193F—1.8(22) Public records and fair information practices. Rescinded ARC 4379C, IAB 3/27/19, effective 5/1/19.

193F—1.9(68B) Sales of goods and services. Rescinded ARC 4379C, IAB 3/27/19, effective 5/1/19.

193F—1.10(17A) Petitions for rule making. Rescinded ARC 4379C, IAB 3/27/19, effective 5/1/19.


193F—1.12(252J,261) Denial of issuance or renewal of license for nonpayment of child support or student loan. Rescinded ARC 4379C, IAB 3/27/19, effective 5/1/19.


193F—1.16(272C) Impaired licensees. Rescinded ARC 4379C, IAB 3/27/19, effective 5/1/19.

193F—1.17(543D) Types of appraiser classifications. There are three types of appraiser classifications:

   1. Associate real property appraiser. This classification consists of those persons who meet the requirements of 193F—Chapter 4.
   2. Certified residential real property appraiser. This classification consists of those persons who meet the requirements of 193F—Chapter 5.
   3. Certified general real property appraiser. This classification consists of those persons who meet the requirements of 193F—Chapter 6.

   [ARC 7774B, IAB 5/20/09, effective 6/24/09]

193F—1.18(543D) Qualified state appraiser certifying agency.

   1.18(1) The real estate appraiser examining board is a state appraiser certifying agency in compliance with Title XI of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (FIRREA). As a result, persons who are issued certificates by the board to practice as certified real estate appraisers are authorized under federal law to perform appraisal services for federally related transactions and are identified as such in the National Registry maintained by the Appraisal Subcommittee (ASC).
1.18(2) The board must adhere to the criteria established by the Appraiser Qualifications Board (AQB) of the Appraisal Foundation when registering associate appraisers or certifying certified appraisers under Iowa Code chapter 543D. To the extent that the rules conflict with the minimum requirements outlined in the current version of the AQB criteria, the minimum standards established in the criteria shall apply and these rules shall give way to the minimum requirements to comply with federal rule, law, or policy.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 6170C, IAB 2/9/22, effective 3/16/22]

193F—1.19(543D) AQB criteria.

1.19(1) No person may be certified as a certified appraiser unless the person is eligible under the January 1, 2022, AQB criteria.

1.19(2) The January 1, 2022, AQB criteria outline the conditions under which applicants for certification are eligible to take the required examinations.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 6375C, IAB 6/29/22, effective 8/3/22]

193F—1.20(543D) Application and work product deadlines.

1.20(1) Summary of registration requirements for registration as an associate. The associate appraiser and supervisory appraiser provisions are more fully set out in 193F—Chapters 4 and 15, respectively. Before submitting an application for registration with the board, a person seeking registration as an associate appraiser must have completed a state and national criminal history check with the board within the past 180 days, have completed 75 hours of appraisal education within the past five years, take a supervisory/Trainee appraiser course, and secure a qualified supervisory appraiser. An associate appraiser applicant who submits an application to the board office must have completed all requirements prior to submitting an application for registration.

1.20(2) Summary of certification requirements. As more fully set out in 193F—Chapters 3, 5, and 6, a person who is in the process of completing the education, experience, and examination required for certification as a certified appraiser may not submit an application for certification to the board until all prerequisites have been satisfactorily completed. The prerequisites include the following: qualifying college and core criteria appraiser education, qualifying examination, 1,500 hours of qualifying experience in a minimum of 12 months for residential appraisers or 3,000 hours of qualifying experience in a minimum of 18 months for general appraisers, work product review, and a state and national criminal history check consistent with Iowa Code section 543D.22. Work product review requires numerous steps, as provided in 193F—5.6(543D) and 193F—6.6(543D). The work product review process includes the applicant’s submission of a work product experience log to the board; the board’s selection of three appraisals to review; communication of the selected appraisals to the applicant; the applicant’s submission of the three appraisals and associated work files to the board in electronic and paper formats; review of the appraisals and work files by a reviewer retained by the board; the reviewer’s submission of review reports to the board; a meeting between the applicant, the applicant’s supervisor, and the board’s work product review committee; a formal board vote at a board meeting; and communication of approval, denial, or deferral to the applicant. All of these steps must be completed before an applicant with approved work product can submit an application for certification to the board office. If the applicant’s supervisor is unable to attend the work product review meeting, the applicant, or the applicant’s supervisor, must submit the circumstances surrounding the absence to the executive officer so that it may be determined if the work product review meeting should be rescheduled.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 4707C, IAB 10/9/19, effective 11/13/19; ARC 5785C, IAB 7/28/21, effective 9/1/21; ARC 6170C, IAB 2/9/22, effective 3/16/22]

193F—1.21(543D) National criminal history check. All applicants for any of the classifications listed in 193F—1.17(543D), including an applicant seeking to upgrade from a certified residential credential to a certified general credential, must satisfactorily complete a state and national criminal history check as a condition of registration as an associate real property appraiser, certification as a residential, or certification as or upgrade to a general real property appraiser. The applicant shall authorize release of
the results of the criminal history check to the board. If the criminal history check was not completed within 180 calendar days prior to the date the license application is received by the board, the board may perform a new state and national criminal history check or may reject and return the application to the applicant. The background check fee is specified in 193F—Chapter 12.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 3084C, IAB 5/24/17, effective 6/28/17; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 6170C, IAB 2/9/22, effective 3/16/22]

193F—1.22(272C,543D) Process for board review of eligibility.

As more fully set forth in, as described in, and in accordance with 193F—Chapter 13, before applying for registration as an associate appraiser or certification as a certified appraiser, a person with a criminal history that may impair registration or certification may request that the board evaluate the prospective applicant’s criminal history.

[ARC 1467C, IAB 5/28/14, effective 7/2/14; ARC 5484C, IAB 2/24/21, effective 3/31/21]

193F—1.23(272C,543D) Applications. Unless otherwise provided by rule of the board, abandoned applications shall be deemed withdrawn. An application is abandoned if the applicant has not accessed or modified the application through the board’s electronic licensing database within the preceding six months, or when approved by the board but the applicant has failed to pay any required fees within 30 calendar days of the date approved by the board. For purposes of this rule, “application” means any request, application, registration, or petition submitted to the board through the licensing database, including but not limited to the following:

1. Add supervisor appraiser;
2. Associate appraiser registration;
3. Conversion application;
4. Course application;
5. Course instructor application;
6. Course provider application;
7. Examination and experience application;
8. Formal wall certificate request;
9. Pre-/post-course approval request;
10. Reactivation application;
11. Reciprocity application;
12. Reinstatement application;
13. Removal of associate from supervisor;
14. Removal of supervisor from associate;
15. Renewal application;
16. Temporary practice permit application;
17. General application to apply military service to an experience or educational requirement for licensure;
18. Background packet request;
19. Petition for waiver from administrative rules;
20. Request for change of legal name;
21. Request for verification (license and/or examination history); or
22. Request to change license address.

[ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5785C, IAB 7/28/21, effective 9/1/21]

These rules are intended to implement Iowa Code sections 543D.4, 543D.5, 543D.7, 543D.17, 543D.20 and 543D.22 and chapter 272C.

[Filed 8/1/91, Notice 5/29/91—published 8/21/91, effective 9/25/91]
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 2/7/96]
[Filed 2/28/96, Notice 1/3/96—published 3/27/96, effective 5/1/96]
[Filed 2/1/02, Notice 11/28/01—published 2/20/02, effective 3/27/02]
[Filed 9/26/02, Notice 8/21/02—published 10/16/02, effective 11/20/02]
[Filed 2/22/07, Notice 1/17/07—published 3/14/07, effective 4/18/07]
[Filed ARC 7774B (Notice ARC 7595B, IAB 2/25/09), IAB 5/20/09, effective 6/24/09]
[Filed ARC 1467C (Notice ARC 1410C, IAB 4/2/14), IAB 5/28/14, effective 7/2/14]
[Filed ARC 2808C (Notice ARC 2710C, IAB 9/14/16), IAB 11/9/16, effective 1/1/17]
[Filed ARC 3084C (Notice ARC 2966C, IAB 3/15/17), IAB 5/24/17, effective 6/28/17]
[Filed ARC 4169C (Notice ARC 4006C, IAB 9/26/18), IAB 12/5/18, effective 1/9/19]
[Filed ARC 4379C (Notice ARC 4224C, IAB 1/16/19), IAB 3/27/19, effective 5/1/19]
[Filed ARC 4707C (Notice ARC 4567C, IAB 7/31/19), IAB 10/9/19, effective 11/13/19]
[Filed ARC 5237C (Notice ARC 5126C, IAB 8/12/20), IAB 10/21/20, effective 11/25/20]
[Filed ARC 5484C (Notice ARC 5261C, IAB 11/4/20), IAB 2/24/21, effective 3/31/21]
[Filed ARC 5785C (Notice ARC 5611C, IAB 5/5/21), IAB 7/28/21, effective 9/1/21]
[Filed ARC 6170C (Notice ARC 6017C, IAB 11/3/21), IAB 2/9/22, effective 3/16/22]
[Filed ARC 6375C (Notice ARC 6254C, IAB 3/23/22), IAB 6/29/22, effective 8/3/22]
CHAPTER 5
CERTIFIED RESIDENTIAL REAL PROPERTY APPRAISER
[Prior to 2/20/02, see rule 193F—3.4(543D) and 193F—Chapter 4]

193F—5.1(543D) General.

5.1(1) The certified residential real property appraiser classification qualifies the appraiser to appraise one- to four-unit residential properties without regard to value or complexity. The classification includes the appraisal of vacant or unimproved land that is utilized for one- to four-unit residential properties or for which the highest and best use is for one- to four-unit residential properties. The classification does not include the appraisal of subdivisions for which a development analysis/appraisal is necessary.

5.1(2) Certification is composed of three parts: education, examination, and experience, which includes work product review.

5.1(3) All certified residential real property appraisers must comply with USPAP.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14]

193F—5.2(543D) Education. Education requirements for an applicant to obtain a certificate as a certified residential real property appraiser shall be in compliance with the criteria as set forth by the Appraiser Qualifications Board (AQB) of the Appraisal Foundation. If an accredited college or university (accredited by the Commission on Colleges, by a regional or national accreditation association, or by an accrediting agency that is recognized by the U.S. Secretary of Education) accepts the College-Level Examination Program® (CLEP) examination(s) and issues a transcript for the examination(s) showing the college’s or university’s approval, the CLEP credit will be considered as credit for the college course.

5.2(1) Collegiate education. There are five options for the collegiate education aspect of the requirements toward certification as a certified residential real property appraiser as specified in the AQB criteria.

5.2(2) Core criteria. In addition to the formal education in subrule 5.2(1), an applicant must meet the current AQB criteria requirements before taking the AQB-approved examination. All courses must be AQB-approved current core criteria to be considered creditable. The creditable class hours under the general certification AQB-approved current core criteria courses satisfy the residential requirement.

5.2(3) Degree program. Credit toward core criteria qualifying education requirements may also be obtained via the completion of a degree in real estate from an accredited degree-granting college or university, provided that the college or university has had its curriculum reviewed and approved by the AQB.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 6170C, IAB 2/9/22, effective 3/16/22]

193F—5.3(543D) Examination. The prerequisite for taking the AQB-approved examination is collegiate education, experience, work product review and completion of all creditable course hours as specified in subrule 5.2(2). The creditable course hours, collegiate education, and all experience must be completed as specified in subrules 5.2(1) and 5.2(2) and rules 193F—5.4(543D) and 193F—5.6(543D) prior to the examination. Equivalency shall be determined through the AQB Course Approval Program or by an alternate method established by the AQB. USPAP qualifying education shall be awarded only when the class is instructed by at least one AQB-certified USPAP instructor who holds a state-issued certified residential or certified general appraiser credential in active status and good standing.

5.3(1) In order to qualify to sit for the certified residential real property appraiser examination, the applicant must complete the board’s application form and provide copies of documentation of completion of all courses claimed that qualify the applicant to sit for the examination.

a. A sufficient application within the meaning of Iowa Code section 17A.18(2) must:

   (1) Be on a form and in the manner prescribed by the board;

   (2) Be signed by the applicant, be certified as accurate, or display an electronic signature by the applicant if submitted electronically;
3. Be fully completed;
4. Reflect, on its face, full compliance with all applicable continuing education requirements; and
5. Be accompanied by the fee specified in 193F—Chapter 12.

b. The core criteria, collegiate education, experience, and work product review must be completed and the documentation submitted to the board at the time of application to sit for the examination.

5.3(2) The board may verify educational credits claimed. Undocumented credits will be sufficient cause to invalidate the examination results pursuant to 193F—paragraph 3.3(2) “c.”

5.3(3) Responsibility for documenting the educational credits claimed rests with the applicant.

5.3(4) An applicant must supply a true and accurate copy of the original examination scores when applying for certification.

5.3(5) If an applicant who has passed an examination does not obtain the related appraiser credential within 24 months after passing the examination, that examination result loses its validity to support issuance of an appraiser credential. To regain eligibility for the credential, the applicant must retake and pass the examination. This requirement applies to individuals obtaining an initial certified credential or upgrading from an associate credential.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5785C, IAB 7/28/21, effective 9/1/21; ARC 6170C, IAB 2/9/22, effective 3/16/22]

193F—5.4(543D) Supervised experience required for initial certification. Except as otherwise permitted herein, all experience required for initial certification pursuant to Iowa Code section 543D.9 shall be performed as a registered associate real property appraiser under the direct supervision of a certified residential or general real property appraiser pursuant to the provisions of 193F—Chapter 15.

5.4(1) Acceptable experience. The board will accept as qualifying experience the documented experience attained while the applicant for initial certification was in an educational program recognized by the Appraiser Qualifications Board and Appraisal Subcommittee as providing qualifying experience for initial certification, whether or not the applicant was registered as an associate real property appraiser at the time the educational program was completed. Such programs, if approved by federal authorities, will incorporate direct supervision by a certified real property appraiser and such additional program features as to satisfy the purpose of requiring that qualifying experience be attained by the applicant as an associate real property appraiser.

5.4(2) Exceptions. Applicants for certified residential real property certification in Iowa may utilize experience obtained in the absence of registration as an associate real property appraiser under the following circumstances:

a. Subject to any requirements or limitations established by applicable federal authorities, including the AQB and ASC, or applicable federal law, rule, or policy, hours qualifying for experience in any jurisdiction, including in a bordering state, will be considered qualifying hours for experience in Iowa without board approval or authorization, as long as the applicant is able to establish by clear and convincing evidence all of the following:

1. A majority of the applicant’s total qualifying experience hours are completed in Iowa under the direct supervision of a certified real property appraiser pursuant to the provisions of 193F—Chapter 15.
2. The qualifying hours obtained in another jurisdiction and claimed as experience hours in Iowa were completed in a jurisdiction under the direct supervision of an active certified real estate appraiser in that jurisdiction as required by the AQB and the jurisdiction’s laws, rules, or policies.
3. The nature of the experience attained in another jurisdiction is qualitatively and substantially equivalent to the experience an associate real property appraiser would receive under the direct supervision of a certified real property appraiser pursuant to the standards established in 193F—Chapter 15.

b. Requests for experience performed in the absence of registration as an associate real property appraiser shall be made on forms prescribed by the board.

1. The burden shall be on the applicant to establish by clear and convincing evidence all of the following:
1. The experience is qualifying experience under the substantive and documentation standards of the AQB and ASC.
2. Denial of the application would impose an undue hardship on the applicant.
3. The nature of the experience attained is qualitatively and substantially equivalent to the experience an associate real property appraiser would receive under the direct supervision of a certified real property appraiser pursuant to the standards established in 193F—Chapter 15.
4. Approval of the application would foster the board’s goal of fair and consistent treatment of applicants.
5. A basis exists beyond the individual control of the applicant to explain why the experience at issue could not have been attained by the applicant as an associate real property appraiser under the direct supervision of a certified real property appraiser.

(2) Among the circumstances the board may consider favorably in ruling on an application for approval of unsupervised experience or experience attained by the applicant in the absence of registration as an associate real property appraiser are:

1. The experience was attained before receiving an associate credential in Iowa in a jurisdiction that, at the time, did not register associate real property appraisers or otherwise offer an associate, trainee or equivalent category of certification.
2. The applicant attained the experience while employed in a county assessor’s office engaged in mass appraisals, and the experience would otherwise qualify under applicable federal standards.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5484C, IAB 2/24/21, effective 3/31/21]

193F—5.5(543D) Demonstration of experience. The experience necessary for certification pursuant to Iowa Code section 543D.9 must meet the requirements of this rule. The objective of the demonstration of experience is to ensure that, before the applicant is issued a certificate, the applicant has obtained sufficient diversified experience to perform an appraisal.

5.5(1) The applicant shall provide to the board an appraisal log that includes all information required by the AQB as a precondition for certification and shall maintain the log contemporaneously with the performance of supervised real property appraisal services. The appraisal log shall, at a minimum, include all information as described in 193F—subrule 4.2(4).

5.5(2) The applicant shall accumulate a total of 1,500 hours of residential appraisal experience in no fewer than 12 months while in active status. While the hours may be cumulative, the 12 months must have elapsed before the applicant can apply to take the examination. Experience claimed must have been performed in compliance with USPAP in which the appraiser demonstrates proficiency in appraisal principles methodology, procedures and reporting conclusions. Acceptable appraisal experience includes, but is not limited to, the following:

a. Fee and staff appraisal;

b. Ad valorem tax appraisal;

c. Review appraisal;

d. Appraisal analysis;

e. Appraisal consulting;

f. Highest and best use analysis;

g. Feasibility analysis/study; and

h. Mass appraisal.

5.5(3) The types of experience set out in 5.5(2) are intended neither to exclude other sorts of appraisal experience nor to prescribe a specified minimum array of experience. However, an applicant who cannot demonstrate a background of experience of the diversity manifested by this rule shall bear the burden of showing that the applicant’s experience is of sufficient quality and diversity to fulfill the objective of the demonstration of experience. A diversity of experience includes, but is not limited to, the following:

a. Performing all approaches to value (i.e., cost, income, sales);

b. Various reporting types;

c. Appropriate use of various forms (e.g., gPAR, 1004) and formats;
d. Various property types (e.g., vacant land, condominium, manufactured home, and rental);

e. Various assignments that include varying scopes of work (e.g., as is, as completed or proposed, foreclosure, rural properties, estates, use of extraordinary assumption or hypothetical conditions); and

f. Diversity in value ranges.

5.5(4) An applicant may be required to appear before the board or its representative to supplement or verify evidence of experience, which shall be in the form of written reports or file memoranda.

5.5(5) The board may require inspection, by the board itself or by its representatives, of documentation relating to an applicant’s claimed experience. Such inspection may be made at the board’s offices or such other place as the board may designate.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5237C, IAB 10/21/20, effective 11/25/20]

193F—5.6(543D) Work product review.

5.6(1) An applicant shall submit a complete appraisal log at the time of application for examination and work product review. Three appraisal reports will be selected to demonstrate a diversity of experience and approaches to value over various time frames for work product review. The applicant shall submit, both electronically and on paper, one copy of each report and work file for each of the selected appraisals along with the appropriate form and fee. The work product submission shall not be redacted by the applicant; however, the applicant may request the reports remain confidential as specified in subrule 5.6(2). The fee for work product review of the appraisals is provided in 193F—Chapter 12. Appraisals may be selected at random from the entire log or within certain types of appraisals. The board reserves the right to request one or more additional appraisals if those submitted by the applicant raise issues concerning the applicant’s competency or compliance with applicable appraisal standards or the degree to which the submitted appraisals are representative of the applicant’s work product. Such additional appraisals may be selected at random from the applicant’s log or may be selected specifically to provide an example of the applicant’s work product regarding a particular type of appraisal.

5.6(2) The board shall treat all appraisals received as public records unless the applicant notifies the board at the time of submission that a submitted appraisal is subject to the confidentiality provisions of appraisal standards or is otherwise confidential under state or federal law. While applicants are encouraged to submit appraisals actually performed for clients, applicants may submit one or more demonstration appraisals if the appraisals are prepared based on factual information in the same manner as applicable to actual appraisal assignments and are clearly marked as demonstration appraisals.

5.6(3) An applicant seeking to upgrade to a certified residential real property appraiser shall submit three residential appraisals for review.

5.6(4) The board will submit the appraisals to a peer review consultant for an opinion on the appraiser’s compliance with applicable appraisal standards.

5.6(5) The work product review process is not intended as an endorsement of an applicant’s work product. No applicant or appraiser shall represent the results of work product review in communications with a client or in marketing to potential clients in a manner which falsely portrays the board’s work product review as an endorsement of the appraiser or the appraiser’s work product. Failure to comply with this prohibition may be grounds for discipline as a practice harmful or detrimental to the public.

5.6(6) The board views work product review, in part, as an educational process. While the board may deny an application based on an applicant’s failure to adhere to appraisal standards or otherwise demonstrate a level of competency upon which the public interest can be protected, the board will attempt to work with applicants deemed in need of assistance to arrive at a mutually agreeable remedial plan. A remedial plan may include additional education, desk review, a mentoring program, or additional precertification experience.

5.6(7) An applicant who is denied certification based on the work product review described in this rule, or on any other ground, shall be entitled to a contested case hearing as provided in rule 193F—20.39(546,543D,272C). Notice of denial shall specify the grounds for denial, which may include any of the work performance-related grounds for discipline against a certified appraiser.
5.6(8) If probable cause exists, the board may open a disciplinary investigation based on the work product review of an applicant. A potential disciplinary action could arise, for example, if the applicant is a certified residential real property appraiser seeking an upgrade to a certified general real property appraiser, or where the applicant is uncertified and is working under the supervision of a certified real property appraiser who cosigned the appraisal report.

5.6(9) After accumulating a minimum of 500 hours of appraisal experience, an applicant may voluntarily submit work product to the board to be reviewed by a peer reviewer for educational purposes only. A maximum of three reports may be submitted for review during the experience portion of the certification process. Work product submitted for educational purposes only will not result in disciplinary action on either the associate appraiser or the associate appraiser’s supervisor so long as the appraisal review does not reveal negligent or egregious errors or omissions. The fee for voluntary submissions of work product for review is provided in 193F—Chapter 12.

5.6(10) The board will retain the appraisals for as long as needed as documentation of the board’s actions for the Appraisal Subcommittee or as needed in a pending proceeding involving the work product of the applicant or the applicant’s supervisor. When no longer needed for such purposes, the work product may be retained or destroyed at the board’s discretion.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 4370C, IAB 3/27/19, effective 5/11/19; ARC 4707C, IAB 10/9/19, effective 11/13/19; ARC 5237C, IAB 10/21/20, effective 11/25/20; ARC 5785C, IAB 7/28/21, effective 9/1/21; ARC 6170C, IAB 2/9/22, effective 3/16/22; ARC 6375C, IAB 6/29/22, effective 8/3/22]

193F—5.7(543D) Background check. A state and national criminal history check shall be performed on any appraiser upgrading to a new credential consistent with Iowa Code section 543D.22.

[ARC 6007C, IAB 11/3/21, effective 12/8/21]

193F—5.8(543D) Practical Applications of Real Estate Appraisal (PAREA). PAREA utilizes simulated experience training and serves as an alternative to the traditional supervisor/trainee experience model. PAREA programs must be AQB-approved and meet all the required elements found in the PAREA section of the most recent AQB criteria. Applicants who met the prerequisites of a PAREA program prior to commencement of training, and who receive a valid certificate of completion from an AQB-approved PAREA program, have met the allotted experience requirements as outlined in the AQB criteria for that specific PAREA program. PAREA program experience allotment will be awarded per the AQB criteria at the time of program completion.

EXAMPLE: An applicant who has completed an AQB-approved licensed residential real property PAREA program may receive 67 percent of the required experience hours toward the certified residential real property credential. Applicants claiming PAREA experience credit may not receive partial credit for PAREA training.

An applicant who did not fulfill the prerequisites of the PAREA training program prior to commencement but received a certificate of completion of that program has not fulfilled the experience requirements of the AQB criteria. In the event that a deficiency in the prerequisites is found, the applicant may be provided an opportunity to correct the deficiency prior to any denial of an application. Applicants may not receive a certificate of completion until all required components of a PAREA program have been successfully completed and approved by a program mentor. A certificate of completion must be signed by an individual from the training entity qualified to verify the applicant’s successful completion. An applicant wishing to utilize PAREA experience must still comply with rules 193F—5.1(543D) through 193F—5.3(543D), subrules 5.5(4) and 5.5(5), and rules 193F—5.6(543D) and 193F—5.7(543D).

[ARC 6375C, IAB 6/29/22, effective 8/3/22]

These rules are intended to implement Iowa Code sections 543D.5, 543D.8, and 543D.9.

[Filed 8/1/91, Notice 5/29/91—published 8/21/91, effective 9/25/91]
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 2/7/96]
[Filed 2/28/96, Notice 1/3/96—published 3/27/96, effective 5/1/96]
[Filed 12/22/97, Notice 11/5/97—published 1/14/98, effective 2/18/98]
[Filed 2/1/02, Notice 11/28/01—published 2/20/02, effective 3/27/02]
[Filed 5/5/02, Notice 3/20/02—published 5/29/02, effective 7/3/02]
[Filed 4/22/05, Notice 3/16/05—published 5/11/05, effective 6/15/05]
[Filed 6/1/07, Notice 3/28/07—published 6/20/07, effective 7/25/07]
[Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 10/3/07]
[Filed 12/7/07, Notice 10/24/07—published 1/2/08, effective 2/6/08]
[Filed ARC 7774B (Notice ARC 7595B, IAB 2/25/09), IAB 5/20/09, effective 6/24/09]
[Filed ARC 1731C (Notice ARC 1631C, IAB 9/17/14), IAB 11/12/14, effective 12/17/14]
[Filed ARC 3084C (Notice ARC 2966C, IAB 3/15/17), IAB 5/24/17, effective 6/28/17]
[Filed ARC 4169C (Notice ARC 4006C, IAB 9/26/18), IAB 12/5/18, effective 1/9/19]
[Filed ARC 4379C (Notice ARC 4224C, IAB 1/16/19), IAB 3/27/19, effective 5/1/19]
[Filed ARC 4707C (Notice ARC 4567C, IAB 7/31/19), IAB 10/9/19, effective 11/13/19]
[Filed ARC 5237C (Notice ARC 5126C, IAB 8/12/20), IAB 10/21/20, effective 11/25/20]
[Filed ARC 5484C (Notice ARC 5261C, IAB 11/4/20), IAB 2/24/21, effective 3/31/21]
[Filed ARC 5785C (Notice ARC 5611C, IAB 5/5/21), IAB 7/28/21, effective 9/1/21]
[Filed ARC 6007C (Notice ARC 5786C, IAB 7/28/21), IAB 11/3/21, effective 12/8/21]
[Filed ARC 6170C (Notice ARC 6017C, IAB 11/3/21), IAB 2/9/22, effective 3/16/22]
[Filed ARC 6375C (Notice ARC 6254C, IAB 3/23/22), IAB 6/29/22, effective 8/3/22]
CHAPTER 6
CERTIFIED GENERAL REAL PROPERTY APPRAISER
[Prior to 2/20/02, see rule 193F—3.3(543D) and 193F—Chapter 4]


6.1(1) The certified general real property appraiser classification qualifies the appraiser to appraise all types of real property.

6.1(2) All certified general real property appraisers must comply with USPAP.

6.1(3) Certification is composed of three parts: education, examination, and experience, which includes work product review.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14]

193F—6.2(543D) Education. Education requirements for an applicant to obtain a certificate as a certified general real property appraiser shall be in compliance with the criteria as set forth by the Appraiser Qualifications Board (AQB) of the Appraisal Foundation.

6.2(1) Collegiate education. Applicants must hold a bachelor’s degree or higher from an accredited college, junior college, community college, or university. If an accredited college or university (accredited by the Commission on Colleges, by a regional or national accreditation association, or by an accrediting agency that is recognized by the U.S. Secretary of Education) accepts the College-Level Examination Program® (CLEP) examination(s) and issues a transcript for the examination(s) showing the college’s or university’s approval, the CLEP credit will be considered as credit for the college course. An applicant who submits a master’s degree or higher as proof of the applicant’s bachelor’s degree must include an affidavit or a copy of the bachelor’s degree attesting that the bachelor’s degree is from an accredited college or university.

6.2(2) Core criteria. In addition to the formal education in 6.2(1), an applicant must meet the current AQB requirements before taking the AQB-approved examination. All courses must be AQB-approved under current core criteria to be considered creditable.

6.2(3) Degree program. Credit toward core criteria qualifying education requirements may also be obtained via the completion of a degree in real estate from an accredited degree-granting college or university, provided that the college or university has had its curriculum reviewed and approved by the AQB.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 6170C, IAB 2/9/22, effective 3/16/22]

193F—6.3(543D) Examination. The prerequisite for taking the AQB-approved examination is collegiate education, experience, work product review and completion of all creditable course hours as specified in subrule 6.2(2). The core criteria hours, collegiate education, and all experience must be completed as specified in subrules 6.2(1) and 6.2(2) and rules 193F—6.4(543D) and 193F—6.6(543D) prior to the examination. Equivalency shall be determined through the AQB Course Approval Program or by an alternate method established by the AQB. USPAP qualifying education shall be awarded only when the class is instructed by at least one AQB-certified USPAP instructor who holds a state-issued certified residential or certified general appraiser credential in active status and good standing.

6.3(1) In order to qualify to sit for the certified general real property appraiser examination, the applicant must complete the board’s application form and provide copies of documentation of completion of all courses claimed that qualify the applicant to sit for the examination.

a. A sufficient application within the meaning of Iowa Code section 17A.18(2) must:
   (1) Be on a form and in the manner prescribed by the board;
   (2) Be signed by the applicant, be certified as accurate, or display an electronic signature by the applicant if submitted electronically;
   (3) Be fully completed;
   (4) Reflect, on its face, full compliance with all applicable continuing education requirements; and
   (5) Be accompanied by the fee specified in 193F—Chapter 12.
b. The core criteria, collegiate education, experience, and work product review must be completed and documentation submitted to the board at the time of application to sit for the examination.

6.3(2) The board may verify educational credits claimed. Undocumented credits will be sufficient cause to invalidate the examination results pursuant to 193F—paragraph 3.3(2)“c.”

6.3(3) Responsibility for documenting the educational credits claimed rests with the applicant.

6.3(4) An applicant must supply a true and accurate copy of the original examination scores when applying for certification.

6.3(5) If an applicant who has passed an examination does not obtain the related appraiser credential within 24 months after passing the examination, that examination result loses its validity to support issuance of an appraiser credential. To regain eligibility for the credential, the applicant must retake and pass the examination. This requirement applies to individuals obtaining an initial certified credential or upgrading from an associate credential.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5785C, IAB 7/28/21, effective 9/1/21; ARC 6170C, IAB 2/9/22, effective 3/16/22]

193F—6.4(543D) Supervised experience required for initial certification. Except as otherwise permitted herein, all experience required to obtain certification as a certified general real property appraiser pursuant to Iowa Code section 543D.9 shall be performed under the direct supervision of a certified general real property appraiser pursuant to the provisions of 193F—Chapter 15.

6.4(1) Acceptable experience. The board will accept as qualifying experience the documented experience attained while the applicant for initial certification was in an educational program recognized by the Appraiser Qualifications Board and Appraisal Subcommittee as providing qualifying experience for certification, whether or not the applicant was registered as an associate real property appraiser at the time the educational program was completed. Such programs, if approved by federal authorities, will incorporate direct supervision by a certified real property appraiser and such additional program features as to satisfy the purpose of requiring that qualifying experience be attained by the applicant as a real property appraiser.

6.4(2) Exceptions. Applicants for certified general real property certification in Iowa may utilize experience obtained in the absence of registration as an associate real property appraiser under the following circumstances.

a. Subject to any requirements or limitations established by applicable federal authorities, including the AQB and ASC, or applicable federal law, rule, or policy, hours qualifying for experience in any jurisdiction, including a bordering state, will be considered qualifying hours for experience in Iowa without board approval or authorization, as long as the applicant is able to establish by clear and convincing evidence all of the following:

1. A majority of the applicant’s total qualifying experience hours are completed in Iowa under the direct supervision of a certified real property appraiser pursuant to the provisions of 193F—Chapter 15.

2. The qualifying hours obtained in the jurisdiction and claimed as experience hours in Iowa were completed in another jurisdiction under the direct supervision of an active certified real estate appraiser in that jurisdiction as required by the AQB and the jurisdiction’s laws, rules, or policies.

3. The nature of the experience attained in another jurisdiction is qualitatively and substantially equivalent to the experience an associate real property appraiser would receive under the direct supervision of a certified real property appraiser pursuant to the standards established in 193F—Chapter 15.

b. Requests for experience performed in the absence of registration as an associate real property appraiser shall be made on forms prescribed by the board.

1. The burden shall be on the applicant to establish by clear and convincing evidence all of the following:

   1. The experience is qualifying experience under the substantive and documentation standards of the AQB and ASC.

   2. Denial of the application would impose an undue hardship on the applicant.
3. The nature of the experience attained is qualitatively and substantially equivalent to the experience an associate real property appraiser would receive under the direct supervision of a certified real property appraiser pursuant to the standards established in 193F—Chapter 15.

4. Approval of the application would foster the board’s goal of fair and consistent treatment of applicants.

5. A basis exists beyond the individual control of the applicant to explain why the experience at issue could not have been attained by the applicant under the direct supervision of a certified general real property appraiser.

(2) Among the circumstances the board may consider favorably in ruling on an application for approval of unsupervised experience or experience attained by the applicant in the absence of registration as an associate real property appraiser are:

1. The experience was attained before receiving an associate credential in Iowa in a jurisdiction that, at the time, did not require direct supervision or register associate real property appraisers or otherwise offer a category of certification.

2. The applicant attained the experience while employed in a county assessor’s office engaged in mass appraisals, and the experience would otherwise qualify under applicable federal standards.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5484C, IAB 2/24/21, effective 3/31/21]

193F—6.5(543D) Demonstration of experience. The experience necessary for certification pursuant to Iowa Code section 543D.9 must meet the requirements of this rule. The objective of the demonstration of experience is to ensure that, before the applicant is issued a certificate, the applicant has obtained sufficient diversified experience to perform an appraisal.

6.5(1) The applicant shall provide to the board an appraisal log that includes all information required by the AQB as a precondition for certification and shall maintain the log contemporaneously with the performance of supervised real property appraisal services. The appraisal log shall, at a minimum, include all information as described in 193F—subrule 4.2(4).

6.5(2) The applicant shall accumulate a total of 3,000 hours of appraisal experience in no fewer than 18 months while in active status, of which 1,500 hours must consist of nonresidential appraisal experience. While the hours may be cumulative, the 18 months must have elapsed before an applicant can be certified. Experience claimed must have been performed in compliance with USPAP where the appraiser demonstrates proficiency in appraisal principles methodology, procedures and reporting conclusions. Acceptable appraisal experience includes, but is not limited to, the following:

a. Fee and staff appraisal;
b. Ad valorem tax appraisal;
c. Review appraisal;
d. Appraisal analysis;
e. Appraisal consulting;
f. Highest and best use analysis;
g. Feasibility analysis/study; and
h. Mass appraisal.

6.5(3) The types of experience set out in 6.5(2) are intended neither to exclude other sorts of appraisal experience nor to prescribe a specified minimum array of experience. However, an applicant who cannot demonstrate a background of experience of the diversity manifested by this rule shall bear the burden of showing that the applicant’s experience is of sufficient quality and diversity to fulfill the objective of the demonstration of experience. A diversity of experience includes, but is not limited to, the following:

a. Performing all approaches to value (i.e., cost, income, sales);
b. Various reporting types;
c. Appropriate use of various forms (e.g., gPAR, 1004) and formats;
d. Various property types (e.g., vacant land, single-family, multifamily, agricultural, retail, industrial, and special purpose);
e. Various assignments that include varying scopes of work (e.g., as is, as completed or proposed, foreclosure, rural properties, acreages, estates, eminent domain, use of extraordinary assumption or hypothetical conditions); and

f. Diversity in value ranges.

6.5(4) An applicant may be required to appear before the board or its representative to supplement or verify evidence of experience, which shall be in the form of written reports or file memoranda.

6.5(5) The board may require inspection, by the board itself or by its representatives, of documentation relating to an applicant’s claimed experience. Such inspection may be made at the board’s offices or such other place as the board may designate.

[ARC 7774B, IAB 5/20/09, effective 6/24/09; ARC 1731C, IAB 11/12/14, effective 12/17/14; ARC 4169C, IAB 12/5/18, effective 1/9/19; ARC 5237C, IAB 10/21/20, effective 11/25/20]

193F—6.6(543D) Work product review.

6.6(1) An applicant shall submit a complete appraisal log at the time of application for examination and work product review. Three appraisal reports will be selected to demonstrate a diversity of experience and approaches to value over various time frames for work product review. The applicant shall submit, both electronically and on paper, one copy of each report and work file for each of the selected appraisals along with the appropriate form and fee. The work product submission shall not be redacted by the applicant; however, the applicant may request the reports remain confidential as specified in subrule 6.6(2). The fee for work product review of the appraisals is provided in 193F—Chapter 12. Appraisals may be selected at random from the entire log or within certain types of appraisals. The board reserves the right to request one or more additional appraisals if those submitted by the applicant raise issues concerning the applicant’s competency or compliance with applicable appraisal standards or the degree to which the submitted appraisals are representative of the applicant’s work product. Such additional appraisals may be selected at random from the applicant’s log or may be selected specifically to provide an example of the applicant’s work product regarding a particular type of appraisal.

6.6(2) The board shall treat all appraisals received as public records unless the applicant notifies the board at the time of submission that a submitted appraisal is subject to the confidentiality provisions of appraisal standards or is otherwise confidential under state or federal law. While applicants are encouraged to submit appraisals actually performed for clients, applicants may submit one or more demonstration appraisals if the appraisals are prepared based on factual information in the same manner as applicable to actual appraisal assignments and are clearly marked as demonstration appraisals.

6.6(3) An applicant seeking original or upgrade certification as a certified general real property appraiser shall submit one residential appraisal and two nonresidential appraisals for review.

6.6(4) The board will submit the appraisals to a peer review consultant for an opinion on the appraiser’s compliance with applicable appraisal standards.

6.6(5) The work product review process is not intended as an endorsement of an applicant’s work product. No applicant or appraiser shall represent the results of work product review in communications with a client or in marketing to potential clients in a manner which falsely portrays the board’s work product review as an endorsement of the appraiser or the appraiser’s work product. Failure to comply with this prohibition may be grounds for discipline as a practice harmful or detrimental to the public.

6.6(6) The board views work product review, in part, as an educational process. While the board may deny an application based on an applicant’s failure to adhere to appraisal standards or otherwise demonstrate a level of competency upon which the public interest can be protected, the board will attempt to work with applicants deemed in need of assistance to arrive at a mutually agreeable remedial plan. A remedial plan may include additional education, desk review, a mentoring program, or additional precertification experience.

6.6(7) An applicant who is denied certification based on the work product review described in this rule, or on any other ground, shall be entitled to a contested case hearing as provided in rule 193F—20.39(546,543D,272C). Notice of denial shall specify the grounds for denial, which may include any of the work performance-related grounds for discipline against a certified appraiser.
6.6(8) If probable cause exists, the board may open a disciplinary investigation based on the work product review of an applicant. A potential disciplinary action could arise, for example, if the applicant is a certified residential real property appraiser seeking an upgrade to a certified general real property appraiser, or where the applicant is uncertified and is working under the supervision of a certified real property appraiser who consigned the appraisal report.

6.6(9) After accumulating a minimum of 500 hours of appraisal experience, an applicant may voluntarily submit work product to the board to be reviewed by a peer reviewer for educational purposes only. A maximum of three reports may be submitted for review during the experience portion of the certification process. Work product submitted for educational purposes only will not result in disciplinary action on either the associate appraiser or the associate appraiser’s supervisor so long as the appraisal review did not reveal negligent or egregious errors or omissions. The fee for voluntary submissions of work product for review is provided in 193F—Chapter 12.

6.6(10) The board will retain the appraisals for as long as needed as documentation of the board’s actions for the Appraisal Subcommittee or as needed in a pending proceeding involving the work product of the applicant or the applicant’s supervisor. When no longer needed for such purposes, the work product may be retained or destroyed at the board’s discretion.

193F—6.7(543D) Background check. A state and national criminal history check shall be performed on any appraiser upgrading to a new credential consistent with Iowa Code section 543D.22.

193F—6.8(543D) Practical Applications of Real Estate Appraisal (PAREA). PAREA utilizes simulated experience training and serves as an alternative to the traditional supervisor/trainee experience model. PAREA programs must be AQB-approved and meet all the required elements found in the PAREA section of the most recent AQB criteria. An applicant who meets the prerequisites of a PAREA program prior to commencement of training, and who receives a valid certificate of completion from an AQB-approved PAREA program, has met the allotted experience requirements as outlined in the AQB criteria for that specific PAREA program. PAREA program experience allotment will be awarded per the AQB criteria at the time of program completion.

EXAMPLE: An applicant who has completed an AQB-approved certified residential real property PAREA program may receive 50 percent of the required experience hours toward the certified general real property credential. However, these hours are not eligible toward the nonresidential real property required experience hours.

Applicants claiming PAREA experience credit may not receive partial credit for PAREA training. An applicant who did not fulfill the prerequisites of the PAREA training program prior to commencement but received a certificate of completion of that program has not fulfilled the experience requirements of the AQB criteria. In the event that a deficiency in the prerequisites is found, the applicant may be provided an opportunity to correct the deficiency prior to any denial of an application. An applicant may not receive a certificate of completion until all required components of a PAREA program have been successfully completed and approved by a program mentor. Certificates of completion must be signed by an individual from the training entity qualified to verify an applicant’s successful completion. An applicant wishing to utilize PAREA experience must still comply with rules 193F—6.1(543D) through 193F—6.7(543D).

193F—6.9(543D) Upgrade from a certified residential real property appraiser to a certified general real property appraiser. To upgrade from a certified residential real property appraiser to a certified general real property appraiser, an applicant must complete the following additional education, examination, supervision, and experience requirements, which include work product review and a
state and national criminal history check as provided in Iowa Code section 543D.22. For all intents and purposes, a certified residential real property appraiser seeking to upgrade to a certified general status will be considered an associate appraiser as it relates to differences between the scope of practice of the two licensure categories, and the upgrade process will generally follow the same registration requirements, supervisory identification and maintenance requirements, and processes and procedures generally applicable to associate appraisers set forth in 193F—Chapter 4.

6.9(1) Education.
   a. Collegete education. Certified residential real property appraisers must satisfy the college-level education requirements as specified in rule 193F—6.2(543D).
   b. Core criteria. In addition to the formal education and core criteria educational requirements originally required to obtain a certified residential credential, an applicant must meet the current AQB requirements before taking the AQB-approved examination.

6.9(2) Examination. An applicant must satisfy the examination requirements as specified in rule 193F—6.3(543D).

6.9(3) Supervision and experience.
   a. Experience. An applicant must satisfy all of the experience requirements as specified in rules 193F—6.4(543D) and 193F—6.5(543D). In obtaining and documenting the 3,000 total experience hours required by subrule 6.5(2), as is the case for initial licensure, such hours must be accumulated in no fewer than 18 months while in active status as, in effect, a registered associate appraiser pursuing an upgrade pursuant to this rule and subject to the supervision of an Iowa-certified appraiser. Notwithstanding the foregoing:

   (1) To the extent residential appraisal experience may be counted toward licensure in accordance with subrule 6.5(2), residential appraisal experience obtained as a certified residential appraiser prior to initiating the upgrade process may be included on the appraisal log and, subject to the work product review process, counted toward the experience-hours requirement for purposes of upgrading from a certified real property appraiser to a certified general real property appraiser; provided that such residential appraisal experience obtained prior to initiating the upgrade process shall not apply toward the 18-month requirement.

   (2) Applicants may request that the board approve experience hours performed in the absence of registration as an associate real property appraiser by filing an application for approval on a form provided by the board, which application will be subject to and governed by the same processes and standards set forth in rule 193F—6.4(543D).
   b. Supervision. Subject to applicable exceptions, all nonresidential experience obtained and applied toward obtaining a certified general credential as part of the upgrade process shall be performed under the direct supervision of a certified general real property appraiser pursuant to the provisions of 193F—Chapter 15 and shall be subject to the identification, notification, maintenance, approval, scope-of-practice, log, and monitoring requirements set forth in 193F—Chapter 4. Both the applicant and the applicant’s supervisor(s) must complete a supervisor/trainee course within the five years prior to the board’s receipt of the associate registration application identifying a supervisor with the board or prior to the applicant’s obtaining or claiming any experience hours under the supervision of that supervisor.

6.9(4) Work product review. An applicant must satisfy the work product review requirements as specified in rules 193F—6.5(543D) and 193F—6.6(543D).

6.9(5) Practical Applications of Real Estate Appraisal. An applicant seeking to upgrade from a certified residential credential to a certified general credential may gain partial experience credit through an AQB-approved PAREA program pursuant to rule 193F—6.8(543D).

6.9(6) Background check. A state and national criminal history check shall be performed on any appraiser upgrading to a new credential consistent with Iowa Code section 543D.22.

These rules are intended to implement Iowa Code sections 543D.5, 543D.8, 543D.9, and 543D.22.


[Filed 8/1/91, Notice 5/29/91—published 8/21/91, effective 9/25/91]

[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 2/7/96]
[Filed 2/28/96, Notice 1/3/96—published 3/27/96, effective 5/1/96]
[Filed 12/22/97, Notice 11/5/97—published 1/14/98, effective 2/18/98]
[Filed 2/1/02, Notice 11/28/01—published 2/20/02, effective 3/27/02]
[Filed 5/5/02, Notice 3/20/02—published 5/29/02, effective 7/3/02]
[Filed 4/22/05, Notice 3/16/05—published 5/11/05, effective 6/15/05]
[Filed 6/1/07, Notice 3/28/07—published 6/20/07, effective 7/25/07]
[Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 10/3/07]
[Filed 12/7/07, Notice 10/24/07—published 1/2/08, effective 2/6/08]
[Filed ARC 7774B (Notice ARC 7595B, IAB 2/25/09), IAB 5/20/09, effective 6/24/09]
[Filed ARC 1731C (Notice ARC 1631C, IAB 9/17/14), IAB 11/12/14, effective 12/17/14]
[Filed ARC 3084C (Notice ARC 2966C, IAB 3/15/17), IAB 5/24/17, effective 6/28/17]
[Filed ARC 4169C (Notice ARC 4006C, IAB 9/26/18), IAB 12/5/18, effective 1/9/19]
[Filed ARC 4379C (Notice ARC 4224C, IAB 1/16/19), IAB 3/27/19, effective 5/1/19]
[Filed ARC 4707C (Notice ARC 4567C, IAB 7/31/19), IAB 10/9/19, effective 11/13/19]
[Filed ARC 5237C (Notice ARC 5126C, IAB 8/12/20), IAB 10/21/20, effective 11/25/20]
[Filed ARC 5484C (Notice ARC 5261C, IAB 11/4/20), IAB 2/24/21, effective 3/31/21]
[Filed ARC 5785C (Notice ARC 5611C, IAB 5/5/21), IAB 7/28/21, effective 9/1/21]
[Filed ARC 6007C (Notice ARC 5786C, IAB 7/28/21), IAB 11/3/21, effective 12/8/21]
[Filed ARC 6170C (Notice ARC 6017C, IAB 11/3/21), IAB 2/9/22, effective 3/16/22]
[Filed ARC 6375C (Notice ARC 6254C, IAB 3/23/22), IAB 6/29/22, effective 8/3/22]
CHAPTER 11
CONTINUING EDUCATION
[Prior to 2/20/02, see 193F—Chapter 6]

193F—11.1(272C,543D) Definitions. For the purpose of these rules, the following definitions shall apply:

“Approved program” means a continuing education program, course, or activity that satisfies the standards set forth in these rules and has received advance approval of the board pursuant to these rules.

“Approved provider” means a person or an organization that has been approved by the board to conduct continuing education programs pursuant to these rules.

“Asynchronous” means that the instructor and student interaction in an educational offering is nonsimultaneous. Students progress at their own pace through structured course content and scheduled quizzes and examinations.

“Board” means the Iowa real estate appraiser examining board.

“Continuing education” means education which is obtained by a person certified to practice real estate appraising in order to maintain, improve, or expand skills and knowledge obtained prior to initial certification or registration, or to develop new and relevant skills and knowledge, all as a condition of renewal.

“Credit hour” means the value assigned by the board, or the AQB, to a continuing or qualifying education program.

“Distance education” means any education process based on the geographical separation of student and instructor. “Distance education” includes asynchronous, synchronous, and hybrid educational offerings.

“Guest speaker” means an individual who teaches an appraisal education program on a one-time-only or very limited basis and who possesses a unique depth of knowledge and experience in the subject matter.

“Hour” means 50 minutes of instruction.

“Hybrid,” also known as a blended course, means a learning environment that allows for both in-person and online (synchronous or asynchronous) interaction.

“Live instruction” means an educational program delivered in a classroom setting where both the student and the instructor are present in the same room.

“Qualifying education” means education that is obtained by a person seeking certification as a real property appraiser prior to initial certification or registration where the minimum length of the education offering is at least 15 hours and the individual successfully completes a proctored, closed-book final examination pertinent to that educational offering.

“Synchronous” means that in an educational offering the instructor and student interact online simultaneously, as in a phone call, video chat or live webinar, or web-based meeting.

[ARC 9865B, IAB 11/30/11, effective 1/4/12; ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 6170C, IAB 2/9/22, effective 3/16/22; ARC 6375C, IAB 6/29/22, effective 8/3/22]

193F—11.2(272C,543D) Continuing education requirements.

11.2(1) Certified residential, certified general and associate appraisers must demonstrate compliance with the following continuing education requirements as a condition of biennial renewal:

a. A minimum of 28 credit hours in approved continuing education programs must be acquired during the two-year renewal period. Carryover hours from a previous renewal period are not allowed.

b. The purpose of continuing education is to ensure that the appraiser participates in a program that maintains and increases the appraiser’s skill, knowledge and competency in real estate appraising. Credit may be granted for educational offerings that are consistent with the purpose of continuing education. A minimum of 21 of the required 28 credit hours must involve courses that address one or more of the subject areas listed in subrule 11.4(2).

c. Appraisers must successfully complete the seven-hour National USPAP Update Course, or its equivalent, each two-year renewal cycle. Equivalency shall be determined through the AQB Course Approval Program or by an alternate method established by the AQB. USPAP continuing education
credit shall be awarded only when the class is instructed by an AQB-certified instructor(s) and when the class is instructed by at least one state-certified residential or state-certified general appraiser. Individuals who are credentialed in more than one jurisdiction shall not have to take more than one seven-hour National USPAP Update Course within a two-calendar-year period for the purposes of meeting AQB criteria.

d. With the exception of continuing education obtained during the 30-day grace period authorized by and subject to and in accordance with 193F—subrule 9.4(2), all continuing education claimed on a biennial renewal must have been acquired during the renewal period. In addition, all continuing education claimed on a biennial renewal must have been actually taken and completed prior to the renewal application being submitted to the board.

11.2(2) All continuing education credit hours may be acquired in approved classroom or distance education programs.

11.2(3) A maximum of 14 of the required 28 credit hours may be claimed by an instructor for teaching one or more approved continuing education programs in an amount equal to the credit hours approved for attendees. Instructors claiming such credit must teach the appraisal course during the renewal cycle in which credit is claimed and may not claim the course more than once in the renewal cycle. The board may request supportive documentation to ascertain course content and to verify the date(s), time, place and hours taught.

11.2(4) An applicant seeking to renew an initial certificate or registration issued less than 185 days prior to renewal is not required to report any continuing education. An applicant seeking to renew an initial certificate or registration issued for 185 days to 365 days prior to renewal must demonstrate completion of at least 14 credit hours which must include the National USPAP Update course or its AQB equivalent. An applicant seeking to renew an initial certificate or registration issued 365 days prior to renewal or more must demonstrate completion of at least 28 credit hours, including 7 credit hours of the most recent National USPAP Update.

11.2(5) Prior to reinstatement or reactivation of a certified general registration or a certified residential registration, a certified credential holder in inactive, retired, or lapsed status must complete all required continuing education hours that would have been required if the certified credential holder was in active status. The required hours must also include the most recent edition of a seven-hour National USPAP Update Course. Waivers may not be granted to credential holders who have failed to meet the continuing education requirements.

11.2(6) During each two-year renewal period, a continuing education program may be taken for credit only once, except USPAP courses as long as it is not the same USPAP course (e.g., an appraiser may take the 2018-2019 USPAP and the 2020-2021 USPAP update course but may not take two 2018-2019 USPAP update courses).

11.2(7) Successful completion of a continuing education program requires that at least 50 minutes of every class hour be attended by the student. Continuing education credits shall not be granted to attendees who are present for less than 50 minutes of every class hour.

11.2(8) An applicant may claim continuing education credits that have been approved by another jurisdiction that has a continuing education requirement for renewal of a real estate appraisal certificate if the applicable program was approved by the other jurisdiction’s appraisal regulatory body or the AQB for continuing education purposes at the time the applicant completed the course. The burden of proof is on the applicant to demonstrate that a claimed course was approved by either the other jurisdiction or the AQB for continuing education purposes at the time the applicant completed the course. All other programs must be approved upon application to the board pursuant to rules 193F—11.4(272C,543D), 193F—11.5(272C,543D) and 193F—11.6(272C,543D).

11.2(9) A person certified or registered to practice real estate appraising in Iowa shall be deemed to have complied with Iowa’s continuing education requirements for periods in which the person is a resident of another state or district having continuing education requirements for real estate appraising and meets all requirements of that state or district. Waivers may not be granted to credential holders who have failed to meet the continuing education requirements. Deferrals may not be granted to credential holders, except in the case of persons returning from active military duty. Credential holders returning
from active military duty may be placed in active status for a period of up to 90 days pending completion of all continuing education requirements. To qualify, the credential holder must submit a request in writing and provide a copy of the military orders.

11.2(10) A person certified or registered to practice real estate appraising in Iowa who completes an education course approved by both the board and another appraiser regulatory body, for which the approved hours vary, will only be allowed to claim the hours approved by the board to meet the requirements of renewal of the person’s associate registration or certified credential in Iowa. A person certified or registered to practice real estate appraising in Iowa who completes an educational course not approved in Iowa, but approved by either the AQB or by another appraiser regulatory body, may claim the hours awarded by either the AQB or the appraiser regulatory body of the other jurisdiction.

193F—11.3 Reserved.


11.4(1) Continuing education programs, as a condition of board approval, must provide a formal program of learning that contributes to the growth in the professional knowledge and professional competence of real estate appraisers.

11.4(2) Continuing education programs dealing with the following subject areas that are integrally related to appraisal topics and that will generally be acceptable include, but are not limited to:

- Ad valorem taxation;
- Agriculture production and economics;
- Agronomy/soil;
- Approaches to value;
- Arbitrations, dispute resolution;
- Courses related to the practice of real estate appraisal or consulting;
- Construction cost or development cost estimating;
- Ethics and standards of professional practice, USPAP;
- Land use planning or zoning;
- Management, leasing, time sharing;
- Property development, partial interests;
- Real estate appraisal law and rules;
- Real estate appraisal (valuations/evaluations);
- Real estate law, easements, and legal interests;
- Real estate litigation, damages, condemnation;
- Real estate financing and investment;
- Real estate appraisal-related computer applications;
- Real estate securities and syndication;
- Developing opinions of real property value in appraisals that also include personal property or business value, or both;
- Seller concessions and impact on value;
- Energy efficient items and “green building” appraisals; and
- Real estate appraisal technology (e.g., drones).

11.4(3) The following programs will not be acceptable:

- Sales promotion meetings held in conjunction with the appraiser’s general business;
- Time devoted to breakfast, lunch or dinner;
- A program certified by the use of a challenge examination. The required number of hours must be completed to receive credit hours;
- Programs that do not provide at least two credit hours.

11.4(4) Continuing education credit will be granted only for whole hours, with a minimum of 50 minutes constituting one hour. For example, 150 minutes of continuous instruction would count as three
credit hours; however, more than 100 minutes but less than 150 minutes of continuous instruction would only count as two hours.

11.4(5) Continuing education credit may be approved for university or college courses, when an official transcript is provided, in qualifying topics according to the following formula: Each semester hour of credit shall equal 15 credit hours and each quarter hour of credit shall equal 10 credit hours.

[ARC 98656B, IAB 11/30/11, effective 1/4/12; ARC 17332C, IAB 11/12/14, effective 12/17/14; ARC 8237C, IAB 10/21/20, effective 11/25/20; ARC 6170C, IAB 2/9/22, effective 3/16/22]

193F—11.5(272C,543D) Standards for provider and program approval. Providers and programs must satisfy the following minimum standards in order to be preapproved in accordance with the procedures established in rule 193F—11.4(272C,543D) and in order to maintain approved status.

11.5(1) The program must be taught or developed by individuals who have the education, training and experience to be considered experts in the subject matter of the program and competent in the use of teaching methods appropriate to the program.

11.5(2) Programs must be taught by instructors who have successfully completed an instructor development workshop within 24 months preceding board approval of the program. Certified USPAP instructors and instructors approved via a course delivery mechanism approval per the AQB criteria shall be considered to have met this requirement.

11.5(3) In determining whether an instructor is qualified to teach a particular program, the board will consider whether the instructor has an ability to teach and an in-depth knowledge of the subject matter.

11.5(4) An instructor may demonstrate the ability to teach by meeting one or more of the following criteria:

a. Hold a bachelor’s degree or higher in education from an accredited college (attach a copy of transcripts);

b. Hold a current teaching credential or certificate in any real estate or real estate-related fields (attach copy);

c. Hold a certificate of completion in the area of instruction from an instructor institute, workshop or school that is sponsored by a member of the Appraisal Foundation (detail specific teaching experiences);

d. Hold a full-time current appointment to the faculty of an accredited college;

e. Other, as the board may determine.

11.5(5) An instructor may demonstrate in-depth knowledge of the program’s subject matter by meeting one or more of the following criteria:

a. Hold a bachelor’s degree or higher from an accredited college with a major in a field of study directly related to the subject matter of the course the instructor proposes to teach, such as business, economics, accounting, real estate or finance (attach copy of transcript);

b. Hold a bachelor’s degree or higher from an accredited college and have five years of appraisal experience related to the subject matter of the course the instructor proposes to teach (attach copy of transcript and document how the instructor’s experience is related to the subject matter the instructor proposes to teach);

c. Hold a generally recognized professional real property appraisal designation or be a sponsor member of the Appraisal Foundation;

d. Other, as the board may determine.

11.5(6) Only AQB-certified USPAP instructors, listed on the website of the Appraisal Foundation may teach the national USPAP courses, or its AQB-approved equivalent.

11.5(7) Course content and materials must be accurate, consistent with currently accepted standards relating to the program’s subject matter and updated no later than 30 days after the effective date of a change in standards, laws or rules.

11.5(8) Programs must have an appropriate means of written evaluation by participants. Evaluations shall include the relevance of the materials, effectiveness of presentation, content, facilities, and such additional features as are appropriate to the nature of the program.
11.5(9) No part of any course shall be used to solicit memberships in organizations, recruit appraisers for affiliation with any organization or advertise the merits of any organization or sell any product or service.

11.5(10) Providers must clearly inform prospective participants of the number of credit hours preapproved by the board for each program and all applicable policies concerning registration, payment, refunds, attendance requirements and examination grading.

11.5(11) Procedures must be in place to monitor whether the person receiving credit hours is the person who attended or completed the program.

11.5(12) Providers must be accessible to students during normal business hours to answer questions and provide assistance as necessary.

11.5(13) Providers must comply with or demonstrate exemption from the provisions of Iowa Code sections 714.14 to 714.25.

11.5(14) Providers must designate a coordinator in charge of each program who will act as the board’s contact on all compliance issues.

11.5(15) Programs shall not offer more than eight credit hours in a single day.

11.5(16) Providers shall not provide any information to the board, the public or prospective students which is misleading in nature. For example, providers may not refer to themselves as a “college” or “university” unless qualified as such under Iowa law.

11.5(17) Providers must establish and maintain for a period of five years complete and detailed records on the programs successfully attended by each Iowa participant.

11.5(18) Providers must issue an individual certificate of attendance to each participant upon successful completion of the program. The certificate must be no larger than 8½” × 11” and must include the provider name and number, program name and number, name of attendee, date program was completed, number of approved credit hours, and the signature of the coordinator or other person authorized by the board.

11.5(19) Program providers and instructors are solely responsible for the accuracy of all program materials, instruction and examinations. Board approval of a provider or program is not an assurance or warranty of accuracy and shall not be explicitly or implicitly marketed or advertised as such.

11.5(20) Providers must apply for approval using forms prescribed by the board.

11.5(21) Providers must notify the board within 30 days when there is a change in the provider’s primary contact, name, business address, or any other change which may affect the provider’s tax identification number or bond requirements with the Iowa college aid commission.

[ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 6170C, IAB 2/9/22, effective 3/16/22; ARC 6375C, IAB 6/29/22, effective 8/3/22]

193F—11.6(272C,543D) Acceptable distance education courses. Distance education is an education process based on the geographical separation of student and instructor. A distance education course is acceptable to meet class hour requirements if it complies with the generic education criteria in the current AQB criteria.

[ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 6375C, IAB 6/29/22, effective 8/3/22]

193F—11.7(272C,543D) Applications for approval of programs. Applications for approval of programs must be submitted on forms prescribed by the board. All non-AQB courses are approved for 24 months, including the month of approval. Programs approved for distance education or by the AQB may be approved by the board. Board approval of a program will only be valid for the shortest period of time such program is approved by either organization.

11.7(1) Approval must be obtained for each program separately. With the exception of hybrid courses, courses that are offered via more than one delivery method will require separate program approvals.

11.7(2) A nonrefundable fee of $50 must be submitted for each program except for programs that are submitted for approval by the primary provider and that have been approved by the Appraiser Qualifications Board through the Course Approval Program (CAP).
11.7(3) All required forms and attachments must be submitted for approval at least 30 days prior to the first offering of each program or, if renewing, within 30 days of the course expiration date. The board will approve or deny each program, in whole or part, within 15 days of the date the board receives a fully completed application. Upon approval of an application for course offering, the board will specify the number of credit hours allowed. Payments for course program applications must be made within 30 calendar days of the date the application is approved by the board or the application approval may be reversed.

11.7(4) Application forms for non-AQB CAP courses will request information including, but not limited to, the following:
   a. Program description;
   b. Program purpose;
   c. Learning objectives that specify the level of knowledge or competency the student should demonstrate upon completing the program;
   d. Description of the instructional methods utilized to accomplish the learning objective;
   e. Identifying information for all guest speakers or instructors and such documentation as is necessary to verify compliance with the instructor qualifications described in subrule 11.5(5);
   f. Copies of all instructor and student program materials or, in the case of a one-time course offering, a statement that attests all instructor and student materials will be submitted to the board within ten calendar days of the course offering;
   g. Copies of all examinations and a description of all grading procedures;
   h. A description of the diagnostic assessment method(s) used when examinations are not given;
   i. Such information as needed to verify compliance with board rules;
   j. The name, address, telephone number, and email address for the program’s coordinator;
   k. Such other information as the board deems reasonably needed for informed decision making.

11.7(5) Application forms for courses that are AQB CAP-approved shall include information as deemed necessary for accurate documentation but may be more limited than information required in subrule 11.7(4).

11.7(6) The board shall assign each provider and program a number. This number shall be placed on all correspondence issued by the board, all subsequent applications by the same provider, and all certificates of attendance issued to participants.

[ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 5785C, IAB 7/28/21, effective 9/1/21; ARC 6176C, IAB 2/9/22, effective 3/16/22; ARC 6375C, IAB 6/29/22, effective 8/3/22]

193F—11.8(272C.543D) Waiver of application fees. Application fees may be waived for approved programs sponsored by a federal, state, or local governmental agency when the program is offered at no cost or at a nominal cost to participants. A request for waiver of application fees should be made by the provider or certificate holder at the time the application is filed with the board.

193F—11.9(272C.543D) Authority to approve education. The executive officer has the authority to approve or deny education applications subject to the applicant’s right to a hearing as provided for in rule 193F—11.13(272C.543D).

[ARC 1732C, IAB 11/12/14, effective 12/17/14]

193F—11.10(272C.543D) Appraiser request for preapproval of continuing education programs. An appraiser seeking credit for attendance and participation in a program which is to be conducted by a provider not accredited or otherwise approved by the board shall apply for approval to the board at least 15 days in advance of the commencement of the activity. The board shall approve or deny the application in writing. Application for prior approval of a continuing education activity shall include the following fee and information:

1. Application fee of $25;
2. School, firm, organization or person conducting the program;
3. Location of the program;
4. Title and hour-by-hour outline of the program, course or activity;
5. Credit hours requested for approval;
6. Date of program; and
7. Principal instructor(s).

193F—11.11(272C,543D) Appraiser request for postapproval of continuing education program. An appraiser seeking credit for attendance and participation in a program that was not conducted by an approved provider or approved by the licensing authority in another state or otherwise approved by the board shall submit to the board a request for credit for the program. Within 15 days after receipt of the request, the board shall advise the requester in writing whether the program is approved and the number of hours allowed. Appraisers not complying with the requirement of this rule may be denied credit for the program. Application for postapproval of a continuing education program shall include the following fee and information:
   1. Application fee of $25;
   2. School, firm, organization or person conducting the program;
   3. Location of the program;
   4. Title of program and description of program;
   5. Credit hours requested for approval;
   6. Date(s) of program;
   7. Student and instructor materials;
   8. Principal instructor(s); and
   9. Verification of attendance.

[ARC 6170C, IAB 2/9/22, effective 3/16/22]

193F—11.12(272C,543D) Review of provider or program. The board on its own motion or upon receipt of a complaint or negative evaluation may monitor or review any approved program or provider and, upon evidence of significant variation in the program presented from the program approved, a violation of board rules, or material misstatement or omission in the application form, may withdraw approval of the provider or program and disallow all or any part of the approved hours granted to the provider. The provider, as a condition of approval, agrees to allow the board or its authorized representatives to monitor ongoing compliance with board rules through means including, but not limited to, unannounced attendance at programs.

193F—11.13(272C,543D) Hearings. In the event of denial, in whole or in part, of any application for approval of a continuing education program or provider, or credit for a continuing education program, or withdrawal of approval of a continuing education program or provider, the provider or appraiser may, within 30 days of the date of mailing of the notice of denial or withdrawal, request a contested case hearing before the board, as provided in rule 193F—20.8(17A).

[ARC 1732C, IAB 11/12/14, effective 12/17/14; ARC 4379C, IAB 3/27/19, effective 5/1/19]

These rules are intended to implement Iowa Code sections 543D.5, 543D.9 and 543D.16 and chapter 272C.

[Filed 8/1/91, Notice 5/29/91—published 8/21/91, effective 9/25/91]
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 2/7/96]
[Filed 12/22/97, Notice 11/5/97—published 1/14/98, effective 2/18/98]
[Filed 2/1/02, Notice 11/28/01—published 2/20/02, effective 3/27/02]
[Filed 5/5/02, Notice 3/20/02—published 5/29/02, effective 7/3/02]
[Filed 4/22/05, Notice 3/16/05—published 5/11/05, effective 6/15/05]
[Filed 2/22/07, Notice 1/17/07—published 3/14/07, effective 4/18/07]
[Filed 6/1/07, Notice 3/28/07—published 6/20/07, effective 7/25/07]
[Filed 12/7/07, Notice 10/24/07—published 1/2/08, effective 2/6/08]
[Filed ARC 7774B (Notice ARC 7595B, IAB 2/25/09), IAB 5/20/09, effective 6/24/09]
[Filed ARC 9865B (Notice ARC 9716B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed ARC 0412C (Notice ARC 0290C, IAB 7/11/12), IAB 10/31/12, effective 12/5/12]
[Filed ARC 0635C (Notice ARC 0534C, IAB 12/26/12), IAB 3/6/13, effective 4/10/13]
[Filed ARC 1732C (Notice ARC 1629C, IAB 9/17/14), IAB 11/12/14, effective 12/17/14]
[Filed ARC 4379C (Notice ARC 4224C, IAB 1/16/19), IAB 3/27/19, effective 5/1/19]
[Filed ARC 5237C (Notice ARC 5126C, IAB 8/12/20), IAB 10/21/20, effective 11/25/20]
[Filed ARC 5785C (Notice ARC 5611C, IAB 5/5/21), IAB 7/28/21, effective 9/1/21]
[Filed ARC 6170C (Notice ARC 6017C, IAB 11/3/21), IAB 2/9/22, effective 3/16/22]
[Filed ARC 6375C (Notice ARC 6254C, IAB 3/23/22), IAB 6/29/22, effective 8/3/22]
EDUCATION DEPARTMENT[281]
Created by 1986 Iowa Acts, chapter 1245, section 1401.
Prior to 9/7/88, see Public Instruction Department[670]
(Replacement pages for 9/7/88 published in 9/21/88 IAC)

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CHAPTER 25
PATHWAYS FOR ACADEMIC CAREER AND EMPLOYMENT PROGRAM;
GAP TUITION ASSISTANCE PROGRAM

DIVISION I
GENERAL PROVISIONS

281—25.1(260H,260I) Scope. The rules in this chapter implement the pathways for academic career and employment (PACE) program under Iowa Code chapter 260H and the gap tuition assistance program under Iowa Code chapter 260I.

[ARC 0102C, IAB 4/18/12, effective 5/23/12; ARC 6380C, IAB 6/29/22, effective 8/3/22]


"Department" means the Iowa department of education.

"Director" means the director of the Iowa department of education.

"Dislocated worker" means an individual eligible for services and benefits under the federal Trade Adjustment Act of 2002, P.L. 107-210. An individual must meet both criteria 1 and 2, plus any one of criteria 3 through 8:

1. The individual is registered for the selective service, if applicable; and
2. The individual is a citizen or national of the United States, a lawfully admitted permanent resident alien, a lawfully admitted refugee or parolee or an individual authorized by the Attorney General to work in the United States.

3. The individual:
   • Has been laid off or terminated, and
   • Is eligible for or has exhausted entitlement to unemployment compensation, and
   • Is unlikely to return to the individual’s previous industry or occupation; or
4. The individual:
   • Is in receipt of a notice of layoff or termination from employment, and
   • Will be entitled to unemployment compensation at the time of layoff or termination, and
   • Is unlikely to return to the individual’s previous industry or occupation; or
5. The individual:
   • Has been laid off or terminated, or has received a termination notice, and
   • Has been employed for a duration of time to sufficiently demonstrate attachment to the workforce, and
   • Is not eligible for unemployment compensation due to insufficient earnings, or has performed services for an employer not covered under the unemployment compensation law, and
   • Is unlikely to return to the individual’s previous industry or occupation; or
6. The individual has been laid off or terminated, or has received notice of layoff or termination, as a result of a permanent closure of or any substantial layoff at a plant, facility or enterprise; or
7. The individual was formerly self-employed and is unemployed from the individual’s business; or

8. The individual:
   • Is a displaced homemaker who has been providing unpaid services to family members in the home, and
   • Has been dependent on the income of another family member, and is no longer supported by that income, and
   • Is unemployed or underemployed, and
   • Is experiencing difficulty in obtaining or upgrading employment.

"Federal poverty level" means the most recently revised poverty income guidelines published by the federal Department of Health and Human Services.

"IWD" means the Iowa workforce development department.

"Low skilled" means an adult individual who is basic skills deficient, has lower level digital literacy skills, has an education below a high school diploma, or has a low level of educational attainment
that inhibits the individual’s ability to compete for skilled occupations that provide opportunity for a self-sufficient wage.

“State board” means the Iowa state board of education.

“Underemployed” means an adult individual who is working less than 30 hours per week, or who is employed any number of hours per week in a job that is substantially below the individual’s skill level and that does not lead to self-sufficiency.

“Unemployed” means an adult individual who is involuntarily unemployed and is actively engaged in seeking employment.

[ARC 0102C, IAB 4/18/12, effective 5/23/12]

281—25.3 to 25.10 Reserved.

DIVISION II
PATHWAYS FOR ACADEMIC CAREER AND EMPLOYMENT (PACE) PROGRAM

281—25.11(260H) Purpose. The pathways for academic career and employment program (hereinafter referred to as PACE) is established to provide funding to community colleges for the development of projects that will lead to gainful, quality, in-state employment for members of target populations by providing them with both effective academic and employment training to ensure gainful employment and customized support services.

[ARC 0102C, IAB 4/18/12, effective 5/23/12; ARC 1875C, IAB 2/18/15, effective 3/25/15]

281—25.12(260H) Target populations. Individuals included in target populations are those individuals who meet one or more of the following:

1. Are deemed by definition to be low skilled.
2. Earn incomes at or below 250 percent of the federal poverty level.
3. Are unemployed.
4. Are underemployed.
5. Are dislocated workers.

[ARC 0102C, IAB 4/18/12, effective 5/23/12; ARC 1875C, IAB 2/18/15, effective 3/25/15]

281—25.13(260H) Eligibility criteria for projects. Projects eligible for funding for PACE shall be projects that further the ability of members of target populations to secure gainful, quality employment; that further partnerships linking community colleges to industry and nonprofit organizations; and that further the following program outcomes:

25.13(1) Enabling members of the target populations to:
   a. Acquire and demonstrate competency in basic skills.
   b. Acquire and demonstrate competency in a specified technical field.
   c. Complete a specified level of postsecondary education.
   d. Earn a national career readiness certificate.
   e. Obtain employer-validated credentials.
   f. Secure gainful employment in high-quality, local jobs.

25.13(2) Meeting economic and employment goals including but not limited to:
   a. Economic and workforce development requirements in each region served by the community colleges as defined by regional advisory boards established pursuant to Iowa Code section 84A.4.
   b. Needs of industry partners in areas including but not limited to the fields of information technology, health care, advanced manufacturing, transportation and logistics, and any other industry designated as in-demand by a regional advisory board established pursuant to Iowa Code section 84A.4.

[ARC 0102C, IAB 4/18/12, effective 5/23/12]

281—25.14(260H) Program component requirements. Program components for a PACE project implemented at a community college shall:

25.14(1) Include measurable and effective recruitment, assessment, and referral activities designed for the target populations.
25.14(2) Integrate basic skills and work-readiness training with occupational skills training.
25.14(3) Combine customized supportive and case management services with training services to help participants overcome barriers to employment.
25.14(4) Provide training services at times, locations, and through multiple, flexible modalities that are easily understood and readily accessible to the target populations. Such modalities shall support open entry, individualized learning, and flexible scheduling, and may include online remediation, learning lab and cohort learning communities, tutoring, and modularization.

[ARC 0102C, IAB 4/18/12, effective 5/23/12]

281—25.15(260H) Pipeline program. Each community college receiving funding for PACE shall develop a pipeline program in order to better serve the academic, training, and employment needs of the target populations. A pipeline program shall have the following goals:

25.15(1) To strengthen partnerships with community-based organizations and industry representatives.
25.15(2) To improve and simplify the identification, recruitment, and assessment of qualified participants.
25.15(3) To conduct and manage an outreach, recruitment, and intake process, along with accompanying support services, reflecting sensitivity to the time and financial constraints and remediation needs of the target populations.
25.15(4) To conduct orientations for qualified participants to describe regional labor market opportunities, employer partners, and program requirements and expectations.
25.15(5) To describe the concepts of the project implemented with funds from PACE and the embedded educational and support resources available through such project.
25.15(6) To outline the basic skills participants will learn and describe the credentials participants will earn.
25.15(7) To describe success milestones and ways in which temporal and instructional barriers have been minimized or eliminated.
25.15(8) To review how individualized and customized service strategies for participants will be developed and provided.

[ARC 0102C, IAB 4/18/12, effective 5/23/12]

281—25.16(260H) Career pathways and bridge curriculum development program. Each community college receiving funding for PACE shall develop a career pathway and bridge curriculum development program in order to better serve the academic, training, and employment needs of the target populations. A career pathways and bridge curriculum development program shall have the following goals:

25.16(1) The articulation of courses and modules, the mapping of programs within career pathways, and the establishment of bridges between credit and noncredit programs.
25.16(2) The integration and contextualization of basic skills education and skills training. This process shall provide for seamless progressions between adult basic education and general education development programs and continuing education and credit certificate, diploma, and degree programs.
25.16(3) The development of career pathways that support the attainment of industry-recognized credentials, diplomas, and degrees.

[ARC 0102C, IAB 4/18/12, effective 5/23/12; ARC 1875C, IAB 2/18/15, effective 3/25/15]

281—25.17(260H) Pathway navigators.

25.17(1) A community college may use moneys for the PACE program to employ pathway navigators to assist students applying for or enrolled in eligible pathways for academic career and employment projects.
25.17(2) Pathway navigators shall provide services and support to aid students in selecting PACE projects that will result in gainful, quality, in-state employment and to ensure students are successful once enrolled in PACE projects. Services the pathway navigators may provide include but are not limited to the following:
a. Interviewing and selecting students for enrollment in PACE projects.
b. Assessing students’ skills, interests, and previous academic and work experience for purposes of placement in PACE projects.
c. Working with students to develop academic and career plans and to adjust such plans as needed.
d. Assisting students in applying for and receiving resources for financial aid and other forms of tuition assistance.
e. Assisting students with the admissions process, remedial education, academic credit transfer, meeting assessment requirements, course registration, and other procedures necessary for successful completion of PACE projects.
f. Assisting in identifying and resolving obstacles to students’ successful completion of PACE projects.
g. Connecting students with useful college resources or outside support services such as access to child care, transportation, and tutoring assistance, as needed.
h. Maintaining ongoing contact with students enrolled in PACE projects and ensuring students are making satisfactory progress toward the successful completion of projects.
i. Providing support to students transitioning from remedial education, short-term training, and classroom experience to employment.
j. Coordinating activities with community-based organizations that serve as key recruiters for PACE projects and assisting students throughout the recruitment process.
k. Coordinating adult basic education services.

[ARC 1875C, IAB 2/18/15, effective 3/25/15]

281—25.18(260H) Regional industry sector partnerships.

25.18(1) A community college may use moneys for the PACE program to provide staff and support for the development and implementation of regional industry sector partnerships within the region served by the community college.

25.18(2) Regional industry sector partnerships may include but are not limited to the following activities:

a. Bringing together representatives from industry sectors, government, education, local workforce boards, community-based organizations, labor, economic development organizations, and other stakeholders within the regional labor market to determine how PACE projects should address workforce skills gaps, occupational shortages, and wage gaps.
b. Integrating PACE projects and other existing supply-side strategies with workforce needs within the region served by the community college.
c. Developing PACE projects that focus on the workforce skills, from entry-level to advanced, required by industry sectors within the region served by the community college.
d. Structuring pathways so that instruction and learning of workforce skills are aligned with industry-recognized standards where such standards exist.

[ARC 1875C, IAB 2/18/15, effective 3/25/15]

281—25.19 Reserved.

DIVISION III
GAP TUITION ASSISTANCE PROGRAM

281—25.20(260I) Purpose. A gap tuition assistance program is established to provide funding to community colleges for need-based tuition assistance to enable applicants to complete continuing education certificate training programs for in-demand occupations.

[ARC 0102C, IAB 4/18/12, effective 5/23/12]

281—25.21(260I) Applicants for tuition assistance.

25.21(1) Eligibility criteria. Eligibility for tuition assistance shall be based on financial need. Applicants may be found eligible for partial or total tuition assistance. Tuition assistance shall not be approved when the community college receiving the application determines that funding for an
applicant’s participation in an eligible certificate program is available from any other public or private funding source.

a. Criteria to determine financial need shall include but not be limited to:

(1) The applicant’s family income for the three months prior to the date of application, or documentation of a life-changing event.
(2) The applicant’s family size.
(3) The applicant’s county of residence.

b. An applicant for tuition assistance under this chapter must have a demonstrated capacity to achieve the following outcomes:

(1) The ability to complete an eligible certificate program.
(2) The ability to enter a postsecondary certificate, diploma, or degree program for credit.
(3) The ability to gain full-time employment.
(4) The ability to maintain full-time employment over a period of time.

c. The community college receiving the application shall, after considering factors including but not limited to the following, approve an applicant for tuition assistance under this chapter only if the community college determines that applicant is likely to succeed in achieving the outcomes described in 25.16(2):

(1) Barriers that may prevent an applicant from completing the certificate program.
(2) Barriers that may prevent an applicant from gaining employment in an in-demand occupation.

25.21(2) Additional provisions.

a. An applicant for tuition assistance under Division III of this chapter shall provide to the gap tuition assistance coordinator at the community college receiving the application documentation of all sources of income.

b. Only an applicant eligible to work in the United States shall be approved for tuition assistance under Division III of this chapter.

c. An application shall be valid for six months from the date of signature on the application.

d. At the discretion of the community college, an applicant may be approved for tuition assistance under Division III of this chapter for more than one eligible certificate program.

e. Eligibility for tuition assistance under Division III of this chapter shall not be construed to guarantee enrollment in any community college certificate program.

f. Eligibility for tuition assistance under Division III of this chapter shall be limited to persons earning incomes at or below 250 percent of the federal poverty level as defined by the most recently revised poverty guidelines published by the U.S. Department of Health and Human Services.

g. Applicants earning incomes between 150 percent and 250 percent, both percentages inclusive, of the federal poverty level as defined by the most recently revised poverty income guidelines published by the U.S. Department of Health and Human Services shall be given first priority for tuition assistance under this chapter. Persons earning incomes below 150 percent of the federal poverty level shall be given secondary priority for tuition assistance under this chapter.

h. An applicant who is eligible for financial assistance pursuant to the federal Workforce Investment Act of 1998, Pub. L. No. 105-220, or the federal Workforce Innovation and Opportunity Act, Pub. L. No. 113-128, shall be ineligible for tuition assistance under this chapter unless such funds budgeted for training assistance for adult, dislocated worker, or youth programs have been fully expended by a workforce region.

[ARC 1875C, IAB 2/18/15, effective 5/25/15; ARC 2309C, IAB 12/9/15, effective 1/13/16; ARC 4700C, IAB 10/9/19, effective 11/13/19]

281—25.22(260I) Eligible costs. Costs of a certificate program eligible for coverage by gap tuition assistance shall include but are not limited to the following:

1. Tuition.
2. Direct training costs.
3. Required books and equipment.
4. Fees, including but not limited to fees for industry testing services and background checks.
5. Costs of providing direct staff support services, including but not limited to marketing, outreach, application, interview, and assessment processes. Eligible costs for this purpose shall be limited to 20 percent of any allocation of moneys to the two smallest community colleges, 10 percent of any allocation of moneys to the two largest community colleges, and 15 percent of any allocation of moneys to the remaining 11 community colleges. Community college size shall be determined based on the most recent three-year rolling average full-time equivalent enrollment.

[ARC 1875C, IAB 2/18/15, effective 3/25/15]

281—25.23(2601) Eligible certificate programs. For the purposes of this chapter, “eligible certificate program” means a program meeting all of the following criteria:

25.23(1) The program is not offered for credit but is aligned with a certificate, diploma, or degree for credit, and does at least one of the following:

a. Offers a nationally, state-, or locally recognized certificate.

b. Offers preparation for a professional examination or licensure.

c. Provides endorsement for an existing credential or license.

d. Represents recognized skill standards defined by an industrial sector.

e. Offers a similar PACE credential or training.

25.23(2) The program offers training or a credential in an in-demand occupation. For the purposes of this chapter, “in-demand occupation” includes occupations in information technology, health care, advanced manufacturing, transportation and logistics, and any other industry designated as in demand by a regional advisory board established pursuant to Iowa Code section 84A.4.

[ARC 1875C, IAB 2/18/15, effective 3/25/15]

281—25.24(2601) Initial assessment. An eligible applicant for tuition assistance under Division III of this chapter shall complete an initial assessment administered by the community college receiving the application to determine the applicant’s readiness to complete an eligible certificate program. The assessment shall include the areas of reading and mathematics. In assessing an applicant under this division, a community college shall use the national career readiness certificate; an assessment eligible under the Adult Education and Family Literacy Act, 20 U.S.C. Ch. 73, and approved by the department for use in an adult education and literacy program; or an established process utilizing valid measures for determining preparedness for the eligible certificate program, which may include processes for measuring academic preparedness used by the community college for placement of students into credit coursework. An applicant shall complete any additional assessments and occupation research required by the gap tuition assistance program or an eligible certificate program, or both.

[ARC 1875C, IAB 2/18/15, effective 3/25/15; ARC 4700C, IAB 10/9/19, effective 11/13/19; ARC 6380C, IAB 6/29/22, effective 8/3/22]

281—25.25(2601) Program interview. An eligible applicant for tuition assistance under Division III of this chapter shall meet with the gap tuition assistance coordinator for an eligible certificate program offered by the community college receiving the application. The gap tuition assistance coordinator shall discuss the relevant industry, any applicable occupation research, and any applicable training relating to the eligible certificate program. The discussion shall include an evaluation of the applicant’s capabilities, needs, family situation, work history, education background, attitude and motivation, employment dates, support needs, and other requirements for an eligible certificate program.

[ARC 1875C, IAB 2/18/15, effective 3/25/15; ARC 4700C, IAB 10/9/19, effective 11/13/19]

281—25.26(2601) Participation requirements.

25.26(1) A participant in an eligible certificate program who receives tuition assistance pursuant to Division III of this chapter shall do all of the following:

a. Maintain regular contact with staff members for the certificate program to document the applicant’s progress in the program.

b. Sign a release form to provide relevant information to community college faculty or case managers.
c. Discuss with staff members for the certificate program any issues that may impact the participant’s ability to complete the certificate program, obtain employment, and maintain employment over a period of time.

d. Attend all required courses regularly.

e. Meet with staff members for the certificate program to develop a job search plan.

25.26(2) A community college may terminate tuition assistance for a participant who fails to meet the requirements of this rule. The participant may utilize the community college’s local appeal process to contest termination from the program. The process to appeal a termination will be provided to a participant through the gap tuition assistance coordinator.

[ARC 1875C, IAB 2/18/15, effective 3/25/15; ARC 4700C, IAB 10/9/19, effective 11/13/19]

281—25.27(260I) Oversight. Statewide oversight, evaluation, and reporting efforts for the gap tuition assistance program are coordinated by the department.

25.27(1) A steering committee consisting of the Iowa department of education, the Iowa workforce development department, and community college continuing education deans and directors is established to determine if the performance measures of the gap tuition assistance program are being met and to correct any deficiencies. The steering committee shall meet at least quarterly to evaluate and monitor the performance of the gap tuition assistance program.

25.27(2) A common intake tracking system is established and shall be implemented consistently by each participating community college. The community colleges will work cooperatively in establishing the system, and the Iowa department of education will assist in gathering required reporting data elements.

25.27(3) The steering committee will develop the required program criteria for PACE and gap tuition assistance-certified programs to be eligible for tuition assistance and program funding. These criteria will be developed based on best practices in the development and delivery of career pathway programs that provide a clear sequence of education coursework and credentials aligned with regional workforce skills need; clearly articulate from one level of instruction to the next; combine occupational skills and remedial adult education; lead to the attainment of a credential or degree; assist with job placement; and provide wraparound social and socioeconomic support services with the goal of increasing the individual’s skills attainment and employment potential.

[ARC 1875C, IAB 2/18/15, effective 3/25/15]

281—25.28(260I) Redistribution of funds. To ensure efficient delivery of services, the department, in consultation with the community colleges, may redistribute funds available to the community colleges for purposes of this division.

[ARC 4700C, IAB 10/9/19, effective 11/13/19]

These rules are intended to implement Iowa Code chapters 260H and 260I.

[Filed ARC 0102C (Notice ARC 0020C, IAB 2/22/12), IAB 4/18/12, effective 5/23/12]
[Filed ARC 1875C (Notice ARC 1783C, IAB 12/10/14), IAB 2/18/15, effective 3/25/15]
[Filed ARC 2309C (Notice ARC 2182C, IAB 10/14/15), IAB 12/9/15, effective 1/13/16]
[Filed ARC 4700C (Notice ARC 4524C, IAB 7/3/19), IAB 10/9/19, effective 11/13/19]
[Filed ARC 6380C (Notice ARC 6301C, IAB 4/20/22), IAB 6/29/22, effective 8/3/22]
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HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498], see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.
Rules transferred from agency number [498] to [441] to conform with the reorganization numbering scheme in general, IAC Supp. 2/1/87.

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APPEALS AND HEARINGS

This chapter applies to contested case proceedings conducted by or on behalf of the department. The definitions in rule 441—7.1(17A) apply to the rules in both Division I and Division II of Chapter 7. [ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.1(17A) Definitions.

“Adverse benefit determination” means any adverse action taken as to any individual’s benefits pursuant to an assistance program administered by the department or on the department’s behalf, excluding determinations related to requests for exceptions to policy.

“Appeals section” means the director’s designee who is charged with administering the department’s appeals.

“Appellant” means a person, including an authorized representative acting on the person’s behalf, seeking to appeal some action pursuant to this chapter.

“Assistance program” means a program administered by the department or on the department’s behalf through which qualifying individuals receive benefits or services. Assistance programs include, but are not necessarily limited to, the Supplemental Nutrition Assistance Program (SNAP), Medicaid, the family investment program, refugee cash assistance, child care assistance, emergency assistance, the family planning program, the family self-sufficiency grant, PROMISE JOBS, state supplementary assistance, the healthy and well kids in Iowa (hawkI) program, foster care, adoption, and aftercare services.

“Authorized representative” means a person lawfully designated by an individual to act on the individual’s behalf or who has legal authority to act on behalf of the individual.

“Contested case” refers to an evidentiary hearing mandated by state or federal constitutional or statutory authority whereupon a presiding officer makes a determination pertaining to the relative rights and obligations of parties to an appeal under this chapter.

“Department” means the Iowa department of human services.

“DIA” means the Iowa department of inspections and appeals and may include presiding officers where appropriate.

“Director” means the director of the department or the director’s designee.

“Enrollee” means any applicant to or recipient of benefits or services pursuant to an assistance program.

“Good cause,” for purposes of this rule, shall have the same meaning as “good cause” for setting aside a default judgment under Iowa Rule of Civil Procedure 1.971.

“In-person hearing” means an appeal hearing where the administrative law judge and appellant are physically present in the same location but witnesses are not required to be physically present.

“Intentional program violation” means deliberately making a false or misleading statement; or misrepresenting, concealing, or withholding facts; or committing any act that is a violation of the Supplemental Nutrition Assistance Program (SNAP), SNAP regulations, or any state law relating to the use, presentation, transfer, acquisition, receipt, possession, or trafficking of SNAP benefits or an electronic benefit transfer (EBT) card. An intentional program violation is determined through a SNAP administrative disqualification hearing, a court conviction, or when an individual signs and returns Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, which may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both.

“Managed care organization” or “MCO” has the meaning assigned to it in rule 441—73.1(249A) and includes prepaid ambulatory health plans.

“Medicaid” means Iowa’s medical assistance program administered under Iowa Code chapter 249A.
“Party-in-interest” refers to the party, including enrollees, whose rights or obligations are the subject of a contested case hearing under this chapter. Parties-in-interest may or may not be the appellant.

“Presiding officer” means an administrative law judge charged with the administration and adjudication of the contested case hearing process for a particular appeal.

“Self-represented” means representing oneself without an attorney.

[ARC 4972C, IAB 3/11/20, effective 4/15/20; ARC 5810C, IAB 7/28/21, effective 9/1/21; ARC 6384C, IAB 6/29/22, effective 9/1/22]

441—7.2(17A) Governing law and regulations. In the absence of an applicable rule in this chapter, the DIA rules found at 481—Chapter 10 govern department appeals. Notwithstanding the foregoing and the rules contained in this chapter, to the extent that federal or state law (including regulations and rules) related to a specific program is more specific than or contradicts these rules or the applicable DIA rules, the program-specific federal or state law shall control. For example, Supplemental Nutrition Assistance Program (SNAP) appeals shall be conducted in accordance with 7 CFR 273.15 and 7 CFR 273.16 as amended to December 8, 2021, and medical assistance appeals shall be conducted in accordance with 42 CFR Part 431, subpart E, and Part 438, subpart F, as both are amended to December 8, 2021.

[ARC 4972C, IAB 3/11/20, effective 4/15/20; ARC 5810C, IAB 7/28/21, effective 9/1/21; ARC 6384C, IAB 6/29/22, effective 9/1/22]

DIVISION I
GENERAL APPEALS PROCESS

441—7.3(17A) When a contested case hearing will be granted.

7.3(1) Requirements. A person shall be granted a contested case hearing if the party-in-interest fulfills all of the following requirements:

a. The party-in-interest is entitled to a contested case hearing;

b. The party-in-interest has an ongoing, specific and personal interest in the outcome of the contested case hearing; and

c. The party-in-interest meets all of the other requirements contained in these rules.

7.3(2) Refusal to process an application. Unless otherwise provided by law, when an appellant seeks a contested case hearing after the department refuses to process an application for benefits or services, a hearing shall be granted.

7.3(3) When a hearing is not granted. A hearing shall not be granted when one of the following issues is appealed:

a. Patient treatment interventions outlined in the patient handbook of the civil commitment unit for sexual offenders.

b. Children have been removed from or placed in a specific foster care setting or preadoptive placement.

7.3(4) Contractual rights not subject to contested case hearing. Unless otherwise provided by law, when an appellant seeks a contested case hearing of an issue predicated upon or governed by the terms of a contract between appellant and another party, including the department, a contested case hearing shall not be provided.

7.3(5) Change in law. A contested case hearing shall not be granted when the sole issue raised is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries to an assistance program.

7.3(6) Competitive procurement bid appeals. Competitive procurement bid appeals shall be adjudicated pursuant to Division II of this chapter.

[ARC 4972C, IAB 3/11/20, effective 4/15/20; ARC 6384C, IAB 6/29/22, effective 9/1/22]

441—7.4(17A) Initiating an appeal.

7.4(1) Exhaustion of remedies. An appellant shall only be granted a contested case hearing if the appellant has exhausted all other appeal remedies available to the party-in-interest. An appellant should refer to program-specific provisions for the appropriate procedures applicable to specific programs.

7.4(2) Medicaid managed care enrollees exhaustion of remedies.
a. A Medicaid managed care enrollee shall be granted a contested case hearing only if the enrollee has either received a decision from a managed care organization in the time and manner required by rule 441—73.12(249A) or has been deemed to have exhausted the managed care organization appeals under paragraph 7.4(2)’h.’

b. If a Medicaid enrollee’s managed care organization fails to provide a decision in the time and manner required by rule 441—73.12(249A), the enrollee shall be deemed to have exhausted the managed care organization’s appeals process and may initiate a contested case hearing.

7.4(3) Time to appeal. For a contested case hearing to be granted, the following timelines must be met:

a. Supplemental Nutrition Assistance Program (SNAP), Medicaid eligibility, healthy and well kids in Iowa (hawki), fee-for-service Medicaid coverage, family planning program and autism support program. For appeals pertaining to Supplemental Nutrition Assistance Program (SNAP), Medicaid eligibility, healthy and well kids in Iowa (hawki), fee-for-service Medicaid coverage, the family planning program or the autism support program, the appellant must appeal on or before the ninetieth day following the date of notice of an adverse benefit determination.

b. Managed care organization medical coverage. For appeals pertaining to medical services coverage under Medicaid managed care, the appellant must appeal on or before the one hundred twentieth day following the date of exhaustion, actual or deemed, of the managed care organization appeal process outlined in rule 441—73.12(249A).

c. Tax offsets. Except for counties appealing an offset under 441—Chapter 14, for appeals of state or federal tax offsets, the appellant must appeal on or before the fifteenth day following the date of notice of the action. For counties appealing a debtor offset under 441—Chapter 14, the county must appeal on or before the thirtieth day following the date of notice of the offset.

d. Iowa individual disaster assistance program. For appeals pertaining to the Iowa individual disaster assistance program, the appellant must appeal on or before the fifteenth day following the date of the department’s reconsideration decision, pursuant to 441—subrule 58.7(1).

e. Iowa disaster case management program. For appeals pertaining to the Iowa disaster case management program, the appellant must appeal on or before the fifteenth day following the date of the department’s reconsideration decision, pursuant to 441—subrule 58.7(1).

f. Dependent adult abuse. For appeals regarding dependent adult abuse, the appellant must appeal within six months of the date of notice of the action as provided in Iowa Code section 235B.10.

g. Child abuse. For appeals regarding child abuse, the person alleged responsible for the abuse must appeal on or before the ninetieth day following the date of notice of the action as provided in Iowa Code section 235A.19. A subject of a child abuse report, other than the alleged person responsible for the abuse, may file a motion to intervene in the appeal on or before the tenth day following the date of notice of the right to intervene.

h. Sex offender risk assessment. For appeals regarding a sex offender risk assessment, the appellant must appeal in writing on or before the fourteenth day following the date of notice.

i. Assistance program overpayments. For appeals pertaining to the family investment program, family assistance, PROMISE JOBS, child care assistance, medical assistance, healthy and well kids in Iowa (hawki), family planning program or Supplemental Nutrition Assistance Program (SNAP) overpayments, the party-in-interest’s right to appeal the existence, computation and amount of the overissuance or overpayment begins when the department sends the first notice informing the party-in-interest of the overissuance or overpayment.

j. All other appeals. For all other appeals, and unless federal or state law provides otherwise elsewhere, the appellant must appeal on or before the thirtieth day following the date of notice of the action being appealed. If such an appeal is made more than 30 days, but less than 90 days, of the date of notice, the director or director’s designee may, at the director’s or designee’s sole discretion, allow a contested case hearing if the delay was for good cause, substantiated by the appellant.

7.4(4) Written and oral notification. The department shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person’s status.
a. Written notification of the following shall be given at the time of application and at the time of any agency action affecting the claim for assistance.
   (1) The right to request a hearing.
   (2) The procedure for requesting a hearing.
   (3) The right to be represented by others at the hearing unless otherwise specified by statute or federal regulation.

b. Written notification shall be given on the application form and all notices of decision.

[ARC 4972C, IAB 3/11/20, effective 4/15/20; AARC 5810C, IAB 7/28/21, effective 9/1/21]

441—7.5(17A) How to request an appeal.

7.5(1) Ways to request a hearing. An appellant may request a contested case hearing:
   a. Via the department’s website,
   b. By telephone, except as specified in subrule 7.5(4),
   c. By mail,
   d. In person, except as specified in subrule 7.5(4), or
   e. Through other commonly available electronic means (such as email or facsimile).

7.5(2) Hearing request. The request for a contested case hearing must be sufficiently detailed so that the department can reasonably understand the action being appealed. The department may request additional information to determine the scope of the appeal. The department may deny if there is not sufficient information to determine the action being appealed.

7.5(3) Filing date. The date of filing for appeal requests sent by regular mail shall be the date postmarked on the envelope sent to the department or, when a postmarked envelope is not available, on the date the appeal is stamped received by the agency. The date of filing for appeal requests sent electronically shall be determined by the date on which the electronic submission was completed.

7.5(4) Appeals that must be filed in writing. Appeal requests pertaining to foster care, adoption, state supplementary assistance, the autism support program, the Iowa individual disaster assistance program, the Iowa disaster case management program, sex offender risk assessment, record check evaluation, child care registered or nonregistered homes, child abuse, dependent adult abuse or child support must be made in writing.

7.5(5) Department’s responsibilities. Unless the appeal is voluntarily withdrawn, the department worker or agent responsible for representing the department at the hearing shall:
   a. Within one working day of receipt of an appeal request, forward Form 470-0487 or 470-0487(S), Appeal and Request for Hearing; the written appeal; the postmarked envelope, if there is one; and a copy of the notification of the proposed adverse action to the appeals section.
   b. Within ten days of the receipt of the appeal, forward a summary and supporting documentation of the worker’s or agent’s factual basis for the proposed action to the appeals section. When practicable, the summary may also include suggested relevant legal authorities.
   c. Copies of all materials sent to the appeals section or the presiding officer to be considered in reaching a decision on the appeal are to be provided to the appellant at the same time as the materials are sent to the appeals section or the presiding officer.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.6(17A) Prehearing procedures.

7.6(1) Acknowledgment of appeal. When the appeals section receives a request for appeal, it shall send acknowledgment of the receipt of the appeal to the parties to the appeal. For appeals regarding child abuse, all subjects other than the person alleged responsible (party-in-interest) will be notified of the opportunity to file a motion to intervene as provided in Iowa Code section 235A.19.

7.6(2) Acceptance or denial of appeal. The appeals section will determine with reasonable promptness whether the party-in-interest is entitled to a contested case hearing under rule 441—7.3(17A). If a request is accepted, the appeals section will certify the appeal to DIA and designate the issues on appeal pursuant to subrule 7.6(3). If a request for a contested case hearing is denied, the appeals section will provide written notice of and the reasons for the denial. On or before the thirtieth day
following the denial, the individual requesting the appeal may provide additional information related to
the individual’s asserted right to a contested case hearing and request reconsideration of the denial.

7.6(3) Designation of issues for appeal.
   a. Initial designation. After determining that the party-in-interest is entitled to a contested case
      hearing, the appeals section will designate the issues to be decided at the contested case hearing. The
      issues identified may include all issues raised by the appellant and may also include additional issues
      identified by the appeals section. The issues designated shall be certified to DIA and be identified in the
      notice of hearing issued pursuant to subrule 7.6(5).
   b. Additional designation of issues. If any party believes additional issues should be designated,
      the party shall identify the additional issues within the following timelines. The presiding officer shall
      determine whether all issues have properly been preserved.
      (1) Child abuse and dependent adult abuse registry appeals. For child abuse and dependent adult
      abuse registry appeals, the party shall identify additional issues at least 30 days before the date of hearing.
      (2) Appeals set on or before the tenth day following the notice of hearing. If the hearing is on or
      before the tenth day following the date of the notice of hearing, the party shall identify any additional
      issues at the hearing.
      (3) All other appeals. For all other appeals not identified in this paragraph, the party shall identify
      the additional issues on or before the tenth day following the date of the notice of hearing.

7.6(4) Group hearings regarding medical assistance. The appeals section may respond to a series
of related, individual requests for hearings regarding medical assistance by consolidating individual
hearings into a single group hearing where the sole issue is based on state or federal law or policy.
An appellant scheduled for a group hearing may withdraw and request an individual hearing.

7.6(5) Notice of hearing.
   a. Issuance of hearing notice. Except as provided in paragraph 7.6(5)”b,” DIA shall send notice to
      the parties of the appeal at least ten calendar days in advance of the hearing setting forth the date, time,
      method, and place of the hearing; that evidence may be presented orally or documented to establish
      pertinent facts; that the parties may bring and question witnesses and refute testimony; and that the
      parties may be represented by others, including an attorney, at the parties’ own cost and as subject to
      state and federal law. Notice shall be mailed by first-class mail, postage prepaid, and addressed to the
      appellant at the appellant’s last-known address.
   b. Intentional program violation hearing notices. DIA shall send notices of hearing regarding
      alleged intentional program violations at least 30 days in advance of the hearing date. The notices under
      this paragraph shall otherwise comply with the requirements of paragraph 7.6(5)”a.”

7.6(6) Appellant’s right to department’s case file. Prior to and during the contested case hearing, the
department must provide enrollees or their authorized representative with the opportunity to examine the
content of the appellant’s case file, if any, and all documents and records to be used by the department
at the hearing.

7.6(7) Informal conference. The purpose of an informal conference is to provide information as to
the reasons for the intended adverse action, to answer questions, to explain the basis for the adverse
action or position, and to provide an opportunity for the appellant to examine the contents of the case
record.
   a. When requested by the appellant, an informal conference with a representative of the
      department or one of its contracted partners, including a managed care organization, shall be held as
      soon as possible after the appeal has been filed. An appellant’s representative shall be allowed to attend
      and participate in the informal conference, unless precluded by federal rule or state statute.
   b. An informal conference need not be requested for the appellant to examine the contents of the
      case record.

[ARC 4972C, IAB 3/11/20, effective 4/15/20; ARC 6384C, IAB 6/29/22, effective 9/1/22]

441—7.7(17A) Timelines for contested case hearings.
7.7(1) Medical assistance. In cases involving the determination of medical assistance, the contested case hearing shall be held within a time frame such that the final administrative action is timely pursuant to 42 CFR 431.244(f) as amended to December 8, 2021.

7.7(2) Community spouse resource allowance. In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

7.7(3) Sex offender risk assessment. In cases involving an appeal of a sex offender risk assessment, the hearing or administrative review shall be held within 30 days of the date of the appeal request.

{ARC 4972C, IAB 3/11/20, effective 4/15/20; ARC 6384C, IAB 6/29/22, effective 9/1/22}

441—7.8(17A) Contested case hearing procedures.

7.8(1) Method. Contested case hearings may be conducted via telephone or videoconference. Upon request of a party to the appeal or order of the presiding officer, the contested case hearing shall be conducted in person.

7.8(2) Evidence.
   a. The parties to a contested case hearing shall be permitted to:
      (1) Bring witnesses,
      (2) Submit competent evidence to establish all pertinent facts and circumstances,
      (3) Present arguments without undue interference,
      (4) Question or refute any testimony or evidence, including through cross-examination, and
      (5) Respond to evidence and arguments on all issues.
   b. Evidence shall be received or excluded as provided in Iowa Code section 17A.14.

7.8(3) Right to counsel. Parties to an appeal shall be permitted to be represented by counsel at the parties’ own expense.

7.8(4) Self-represented appellants. The presiding officer shall, at the officer’s discretion, provide reasonable assistance to self-represented appellants. The presiding officer must, however, ensure that such assistance does not impact the independence and fairness of the contested case hearing process.

7.8(5) Closed to public. Contested case hearings are closed to the public, and unless otherwise provided by state or federal law, only the parties, their representatives, permissible intervenors, and witnesses may be present for a contested case hearing in the absence of mutual agreement of the parties.

7.8(6) Administration of appeals. Except as otherwise provided in this chapter or other applicable federal or state law, discretion in the conduct and administration of appeals is vested in the contested case hearing presiding officer.

7.8(7) Contested cases with no factual dispute. If the parties in a contested case agree that there is no dispute of material fact, the parties may present all admissible evidence either by stipulation, or as otherwise agreed, in lieu of an evidentiary hearing. If an agreement is reached, the parties shall jointly submit a schedule for submission of the record, briefs and oral arguments to the presiding officer for approval.

{ARC 4972C, IAB 3/11/20, effective 4/15/20}

441—7.9(17A) Miscellaneous rules governing contested case hearings.

7.9(1) Ex parte communication. Ex parte communications between the presiding officer and person or party in connection with any issue of fact or law in the contested case proceeding is prohibited except as permitted by Iowa Code section 17A.17. All of the provisions of Iowa Code section 17A.17 apply.

7.9(2) Default. If a party fails to appear at a scheduled hearing or prehearing conference without good cause as determined by the presiding officer, the party’s appeals may be denied and dismissed or may be heard and ruled upon, consistent with Iowa Code section 17A.12. Defaulting parties may file a timely motion to vacate, which shall be granted if the presiding officer determines good cause has been shown.

7.9(3) Withdrawal. An appellant may submit a withdrawal of a fair hearing request at any time prior to hearing through any of the methods identified in subrule 7.5(1), except for programs listed in subrule 7.5(4). For programs listed in subrule 7.5(4), a written request may be submitted via the department’s
website, by mail, in person, or through other commonly available electronic means (such as email or facsimile). Unless otherwise provided, a withdrawal shall be with prejudice.

7.9(4) Medical assessment. For Medicaid enrollees engaged in an appeal involving medical issues, the department may request, at the department’s own expense, that the appellant submit to an appropriate medical assessment. The presiding officer shall order such assessment upon sufficient showing of necessity.

7.9(5) Standard of review. In child abuse appeals, the criteria and level of deference by which the presiding officer shall render a decision is based on a preponderance of evidence.

7.9(6) Interpreters. The department shall provide translation and interpretation services to appellants not fluent in English. Appellants are entitled to have an interpreter present during appeal hearings. In all cases when an appellant is illiterate or semiliterate, the presiding officer shall advise the appellant of the appellant’s rights to the satisfaction of the appellant’s understanding.

7.9(7) Persons living with disabilities. Persons living with disabilities shall be provided assistance through the use of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

[ARC 4972C, IAB 3/11/20, effective 4/15/20; ARC 6384C, IAB 6/29/22, effective 9/1/22]

441—7.10(17A) Proposed decision.

7.10(1) Contents. The presiding officer shall issue a written proposed decision to all parties clearly identifying the issues on appeal, holding, findings of fact, conclusions of law, and order. The findings of fact shall cite and be based exclusively on the record as defined by Iowa Code section 17A.12(6). The conclusions of law shall be limited to the contested issues of fact, policy or law and shall identify the specific provisions of law that support the ultimate conclusion.

7.10(2) Access to record. After receiving the proposed decision, appellants shall be given reasonable access to the record at a convenient place and time.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.11(17A) Director’s review.

7.11(1) Time. Parties, including the department, may appeal the proposed decision to the director.

a. A request for director’s review shall be in writing and postmarked or received within 14 calendar days of the date on which the proposed decision was issued, except as provided for under subrule 7.11(1)”b.” A request for director’s review may be accompanied by a brief written summary of the arguments in favor of director’s review.

b. A managed care organization appealing a proposed decision reversing an adverse benefit determination shall request director’s review within 72 hours from the date it received notice of the proposed decision.

7.11(2) Grant or denial of review. The department has full discretion to grant or deny a request for review. In addition, the director may initiate review of a proposed decision on the director’s own motion at any time on or before the fourteenth day following the issuance of the proposed decision.

When the department grants a request for director’s review, the appeals section shall notify the parties to the appeal of the review request and enclose a copy of the request. All other parties shall have 14 calendar days from the date of notification to submit further written arguments or objections for consideration upon review.

7.11(3) Cross-appeal. When a party requests director’s review in accordance with subrule 7.11(1), the remaining parties shall have 14 calendar days from that date to submit cross-requests for director’s review. The party originally seeking director’s review shall have 14 calendar days from the date of the cross-request for director’s review to submit further written arguments or objections for consideration upon review.

7.11(4) Limited record. Director’s review shall be limited to the issues and record before the contested case hearing presiding officer.

7.11(5) Oral arguments. Upon specific request, the director may, at the director’s discretion, permit parties to present oral arguments with the parties’ requests for director’s review.

[ARC 4972C, IAB 3/11/20, effective 4/15/20; ARC 6384C, IAB 6/29/22, effective 9/1/22]
441—7.12(17A) Final decisions.

7.12(1) No appeal or denial of director review. If there is no timely appeal from or review of the proposed decision, the presiding officer’s proposed decision becomes the final decision of the agency.

7.12(2) Timelines.

a. The department or director will issue a final decision within the timelines prescribed by federal or state law. For all appeals for which there is no federal or state timeliness standard, the department or director will issue a final decision on or before the ninetieth day from the date the department receives an appeal request.

b. Except as otherwise provided by state or federal law, the time frames for a final decision provided under this rule may be tolled when:

1. The appellant requests a delay;
2. The appellant fails to take a required action; or
3. There is an administrative or other emergency beyond the department’s control.

c. DIA shall document in the record the reasons for any delay and the requesting party.

7.12(3) Written notice of final decision. The parties to the appeal shall be provided written notice of the department’s final decision. The department shall also notify the appellant of the appellant’s right to seek judicial review, where applicable.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.13(17A) Expedited review.

7.13(1) Expedited review criteria. Appellants to a medical assistance appeal may, at any time, file with the department a request for expedited review of the appeal. Expedited review shall be granted when the department determines, or a provider acting on behalf or in support of an appellant indicates, that taking the time for a standard resolution could seriously jeopardize the party-in-interest’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.

7.13(2) Managed care expedited proceedings.

a. If the appellant is granted an expedited review pursuant to subrule 73.12(2), all subsequent proceedings shall also be expedited without an additional request if the appeal request indicates that the managed care organization appeal was expedited and provides the basis for expedited relief.

b. When review is expedited pursuant to paragraph 7.13(2)“a,” the presiding officer shall issue a proposed decision as expeditiously as the enrollee’s health condition requires, but no later than three working days after the department receives from the managed care organization the case file and information for any appeal of a denial of a service that, as indicated by the managed care organization:

1. Meets the criteria for expedited resolution but was not resolved within the time frame for expedited resolution; or
2. Was resolved within the time frame for expedited resolution but reached a decision wholly or partially adverse to the enrollee.

7.13(3) Medicaid eligibility, nursing facility transfers or discharges, or preadmission and annual resident review expedited proceedings. For expedited appeals related to Medicaid eligibility, nursing facility transfers or discharges, or preadmission and annual resident review requirements, the presiding officer shall issue a proposed decision as expeditiously as possible, but no later than seven working days after the department receives a request for expedited fair hearing.

7.13(4) Medicaid-covered benefits or services expedited proceedings. For expedited appeals related to Medicaid-covered benefits or services, the presiding officer shall issue a proposed decision as expeditiously as possible, but no later than provided in paragraph 7.13(2)“b.”

7.13(5) Final decision for expedited proceeding. The department shall issue its final decision in accordance with this rule, except as provided by subrule 7.12(2).

7.13(6) Notification if expedited relief is granted or denied. The department shall notify the appellant as expeditiously as possible whether the request for expedited relief is granted or denied. Such notice must be provided orally or through electronic means to the extent consistent with federal and state law.
If oral notice is provided, the department shall follow up with written notice, which may be through electronic means to the extent consistent with federal and state law.
[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.14(17A) Effect.

7.14(1) If the contested case hearing presiding officer’s proposed decision is favorable to an enrollee in a Medicaid appeal, the department must promptly make corrective payments retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility. If the presiding officer reverses a decision of a managed care organization to deny, limit, or delay services that were not furnished while the appeal was pending, the managed care organization must authorize or provide the disputed services promptly and as expeditiously as the enrollee’s health condition requires, but no later than 72 hours from the date the managed care organization receives notice reversing the determination.

7.14(2) Unless there is contravening federal or state law, all final decisions shall be put into effect within seven days of the issuance of the final decision.
[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.15(17A) Calculating time. In computing any time period specified in this chapter, the period:
1. Excludes the day of the event that triggers the period;
2. Includes every day of the time period (including Saturdays, Sundays, and holidays on which the department is closed); and
3. Includes the last day of the period, but if the last day is a Saturday, Sunday, or legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday.
[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.16(17A) Authorized representatives.

7.16(1) Regulations. The provisions of this rule only apply to the extent the standards expressed in this rule are not in conflict with other state or federal law.

7.16(2) Designation of authority. Legally recognized delegations of authority, such as guardianships, applicable designations of power of attorney, or similar designations, shall be sufficient for a delegate to serve as authorized representative under this chapter. A person who is not designated a legally recognized delegation of authority but who otherwise seeks to act as an authorized representative for an individual in an appeal under this chapter shall provide a written, signed designation of authority to the department with the request for appeal. The designation must provide the scope of the representation, applicable waivers for the release of confidential information, and any temporal or other limitations on the scope of representation. An authorized representative of a party-in-interest only represents the party-in-interest and has no independent right to appeal by virtue of the authorized representative’s representation.

7.16(3) Written designation. For persons other than attorneys seeking to act as authorized representative of a party-in-interest in a Medicaid managed care appeal, the authorized representative’s written designation of authority pursuant to subrule 7.16(2) shall be Form 470-5526, Authorized Representative for Managed Care Appeals. This form is required for all managed care appeals, including those handled through the expedited appeals process. Failure to provide the form or legal documentation may result in denial of the appeal request.

7.16(4) Appearance by attorney. Legal counsel appearing on behalf of any person in a proceeding under this chapter shall enter an appropriate written appearance identifying the legal counsel.
[ARC 4972C, IAB 3/11/20, effective 4/15/20; ARC 6384C, IAB 6/29/22, effective 9/1/22]

441—7.17(17A) Continuation and reinstatement of benefits.

7.17(1) Programs for which no federal or state law applies. For all assistance programs for which there is no contravening federal or state law, benefits or services shall not be suspended, reduced, restricted, or discontinued, nor shall a license, registration, certification, approval, or accreditation be revoked or other adverse action taken pending a final decision when:
a. An appeal is filed before the effective date of the intended action; or

b. The appellant requests a hearing within ten days of receipt of a notice to suspend, reduce, restrict, or discontinue benefits or services. The date on which the notice is received is considered to be five days after the date on the notice, unless the appellant shows the notice was not received within the five-day period.

7.17(2) Sole issue is state or federal law or policy. Benefits or services continued pursuant to subrule 7.17(1) may be suspended, reduced, restricted, or discontinued if the presiding officer determines at the contested case hearing that the sole issue is one of state or federal law or policy and the department has notified the enrollee in writing that services are to be suspended, reduced, restricted, or discontinued pending the proposed decision.

7.17(3) Recoup cost of services or benefits. The department or managed care organization may recoup the cost of benefits or services provided pursuant to this chapter if the adverse action appealed from is affirmed, consistent with state and federal law.

[ARC 4972C; IAB 3/11/20, effective 4/15/20]

441—7.18(17A) Emergency adjudicative proceedings.

7.18(1) Necessary emergency action. When and to the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with state and federal law, a contested case hearing presiding officer may issue a written order to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order. In determining the necessity of such an action, the presiding officer shall consider factors including, but not limited to, the following:

a. Whether there has been sufficient investigation and evidentiary support to ensure the order is proceeding based on reliable information;

b. Whether the specific circumstances giving rise to the potential order have been specifically identified and determined to be continuing;

c. Whether the person who is required to comply with the emergency adjudicative order may continue to engage in other activities without risk of immediate danger to the public health, safety, or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety, or welfare; and

e. Whether the specific action contemplated is necessary to avoid the immediate danger.

7.18(2) Issuance of order. An emergency adjudicative order shall contain, or shall be expeditiously followed by, a written analysis, including findings of fact, conclusions of law, and policy reasons to justify the order. The agency shall provide written notice that best ensures prompt, reliable delivery. Such order shall be immediately delivered to the persons required to comply with the order.

7.18(3) Completion of proceedings. Upon issuance of an order under this rule, the department shall proceed as quickly as reasonably practicable to complete any proceedings that would be required if the matter did not involve an immediate danger. An order issued under this rule shall include notice of the date on which proceedings under this chapter are to be completed. After issuance of an order under this rule, continuance of further proceedings under this chapter shall only be granted in compelling circumstances upon application in writing. Before issuing an emergency adjudicative order, the presiding officer shall consider factors including, but not limited to, the following:

a. Whether there has been sufficient investigation and evidentiary support to ensure the order is proceeding based on reliable information;

b. Whether the specific circumstances giving rise to the potential order have been specifically identified and determined to be continuing;

c. Whether the person who is required to comply with the emergency adjudicative order may continue to engage in other activities without risk of immediate danger to the public health, safety, or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety, or welfare; and
e. Whether the specific action contemplated is necessary to avoid the immediate danger.

[ARC 4972C; IAB 3/11/20, effective 4/15/20]

441—7.19(17A) Supplemental Nutrition Assistance Program (SNAP) administrative disqualification hearings. The department acts on alleged intentional program violations either through an administrative disqualification hearing or referral to a court of appropriate jurisdiction. An individual accused of an intentional program violation may waive the individual’s right to an administrative disqualification hearing in accordance with the procedures outlined in this rule and in 7 CFR 273.16(e) and (f) as amended to December 8, 2021.

7.19(1) When a case is referred for an administrative disqualification hearing, the appeals section shall mail written notification to the individual that the individual can waive the right to an administrative disqualification hearing by signing and returning Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing.

7.19(2) By signing Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, the individual:
   a. Waives the right to an administrative disqualification hearing;
   b. Consents to the SNAP disqualification period designated on Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, and a reduction of benefits for the period of disqualification; and
   c. Acknowledges that remaining household members, if any, may be held responsible for repayment of the resulting claim.

7.19(3) An administrative disqualification hearing shall be scheduled if the individual does not sign and mail or fax Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, to the appeals section within ten days of receipt of the written notification stating the individual can waive the right to an administrative disqualification hearing. The date on which the written notification is received is considered to be five days after the date on the notification, unless the individual shows the notification was not received within the five-day period.

7.19(4) An individual who waives the right to an administrative disqualification hearing will be subject to the same penalties as an individual found to have committed an intentional program violation in an administrative disqualification hearing.

7.19(5) No further administrative appeal procedure exists after an individual waives the individual’s right to an administrative disqualification hearing and a disqualification penalty has been imposed. The disqualification penalty shall not be changed by a subsequent fair hearing decision.

[ARC 5810C; IAB 7/28/21, effective 9/1/21; ARC 6384C; IAB 6/29/22, effective 9/1/22]

441—7.20 to 7.40 Reserved.

DIVISION II

APPEALS BASED ON THE COMPETITIVE PROCUREMENT BID PROCESS

441—7.41(17A) Scope, bidder and applicability. The rules in Division II apply to appeals based on the department’s competitive procurement bid process. A bidder is an entity that submits a proposal in response to a solicitation issued through the department of human services’ competitive procurement process.

[ARC 1206C; IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.42(17A) Requests for timely filing of an appeal. Any bidder that receives either a notice of disqualification or a notice of award, and has first exhausted the reconsideration process, is considered an aggrieved party and may file a written appeal with the department.

7.42(1) An aggrieved party in a competitive procurement must seek reconsideration of a disqualification or a notice of award prior to filing any appeal. The request for reconsideration must be received by the department within five days of the date of either a disqualification notice or notice of award. The department will expeditiously address the request for reconsideration and issue a decision on the reconsideration. If the party seeking reconsideration continues to be an aggrieved party following
receipt of the decision on reconsideration, the aggrieved party may file an appeal within five days of the
date of the department’s decision on reconsideration.

7.42(2) The written appeal shall state the grounds upon which the appellant challenges the
department’s decision.

7.42(3) The day after the department’s decision on reconsideration is issued is the first day of the
period in which the appeal may be filed. The mailing address is: Department of Human Services, Appeals
Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Appeals may also be sent by fax, email,
or in-person delivery.

When an appeal is submitted through an electronic delivery method, such as electronic mail or
facsimile, the appeal is filed on the date it is submitted. The electronic delivery method shall record the
date and time the appeal request was submitted. If there is no date recorded by the electronic delivery
method or the appeal was filed via in-person delivery, the date of filing is the date the appeal is stamped
received by the agency. Receipt date of all appeals shall be documented by the office where the appeal
is received.

When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next
workday.

[ARC 1206C; IAB 12/11/13, effective 1/15/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.43(17A) Bidder appeals. The bidder appeal shall be a contested case proceeding and shall be
conducted in accordance with the provisions of Division II. Division I of this chapter does not apply to
competitive procurement bid appeals, unless otherwise noted.

7.43(1) Hearing time frame. The presiding officer shall hold a hearing on the bidder appeal within
60 days of the date the notice of appeal was received by the department.

7.43(2) Registration. Upon receipt of the notice of appeal, the department shall register the appeal.

7.43(3) Acknowledgment. Upon receipt of the notice of appeal, the department shall send a written
acknowledgment of receipt of the appeal to the appellant, representative, or both. The appropriate
department staff will be notified of the appeal.

7.43(4) Granting a hearing. The department shall determine whether an appellant may be granted
a hearing and the issues to be discussed at the hearing in accordance with the applicable rules, statutes
or federal regulations or request for proposal.

a. The appeals of those appellants who are granted a hearing shall be certified to the department
of inspections and appeals for the hearing to be conducted. The department shall indicate at the time of
certification the issues to be discussed at the hearing.

b. Appeals of those appellants that are denied a hearing shall not be closed until a letter is sent to
the appellant and the appellant’s representative advising of the denial of the hearing and the basis upon
which that denial is made. Any appellant that disagrees with a denial may present additional information
relative to the reason for denial and request reconsideration by the department over the denial.

7.43(5) Hearing scheduled. For those records certified for hearing, the department of inspections
and appeals shall establish the date, time, method and place of the hearing, with due regard for the
convenience of the appellant as set forth in the department of inspections and appeals rules in
481—Chapter 10 unless otherwise designated by federal or state statute or regulation.

7.43(6) Method of hearing. The department of inspections and appeals shall determine whether the
appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties
to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any
appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the
same rights during a teleconference hearing as specified in rule 441—7.8(17A).

7.43(7) Reschedule requests. Requests made by the appellant or the department to set another date,
time, method or place of hearing shall be made to the department of inspections and appeals, except as
otherwise noted. The granting of the requests will be at the discretion of the department of inspections
and appeals. All requests concerning the scheduling of a hearing shall be made to the department of
inspections and appeals directly.
7.43(8) **Notification.** For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. The notice shall comply with Iowa Code section 17A.12(2), and include a statement that opportunity shall be afforded to all parties to respond and present evidence on all issues involved and to be represented by counsel at their own expense.

b. A copy of this notice shall be made available to the department employee who took the action and to any other parties to the appeal.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.44(17A) **Procedures for bidder appeal.**

7.44(1) Discovery. The parties shall serve any discovery requests upon other parties at least 30 days prior to the date set for the hearing. The parties must serve responses to discovery at least 15 days prior to the date set for the hearing.

7.44(2) Witnesses and exhibits. The parties shall contact each other regarding witnesses and exhibits at least ten days prior to the date set for the hearing. The parties must meet prior to the hearing regarding the evidence to be presented in order to avoid duplication or the submission of extraneous materials.

7.44(3) Amendments to notice of appeal. The aggrieved bidder may amend the grounds upon which the bidder challenges the department’s award no later than 15 days prior to the date set for the hearing.

7.44(4) If the hearing is not conducted in person, the parties must deliver all exhibits to the office of the presiding officer at least three days prior to the time the hearing is conducted.

7.44(5) The presiding officer shall issue a proposed decision in writing that includes findings of fact and conclusions of law stated separately. The decision shall be based on the record of the contested case and shall conform to Iowa Code chapter 17A. The presiding officer shall send the proposed decision to the appellant and representative by mail.

7.44(6) The record of the contested case shall include all materials specified in Iowa Code subsection 17A.12(6).

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.45(17A) **Stay of agency action for bidder appeal.**

7.45(1) **When a stay may be requested.**

a. Any party appealing an issuance of a notice of disqualification or notice of award may petition for stay of the decision pending its review. The petition for stay shall be filed with the notice of appeal, shall state the reasons justifying a stay, and shall be accompanied by an appeal bond equal to 120 percent of the contract value.

b. Any party adversely affected by a final decision and order may petition the department for a stay of that decision and order pending judicial review. The petition for stay shall be filed with the director within five days of receipt of the final decision and order and shall state the reasons justifying a stay.

7.45(2) **When a stay is granted.** In determining whether to grant a stay, the director shall consider the factors listed in Iowa Code section 17A.19(5) “c.”

7.45(3) **Vacation.** A stay may be vacated by the issuing authority upon application of the department or any other party.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.46(17A) **Request for review of the proposed decision.** A request for review of the proposed decision shall follow the provisions outlined in rule 441—7.11(17A).

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 3787C, IAB 5/9/18, effective 7/1/18, ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.47(17A) **Other procedural considerations.**

7.47(1) **Consolidation—severance.**

a. **Consolidation.** The presiding officer may, upon motion by any party or the presiding officer’s own motion, consolidate any or all matters at issue in two or more contested case proceedings where:

1. The matters at issue involve common parties or common questions of fact or law;
2. Consolidation would expedite and simplify consideration of the issues; and
(3) Consolidation would not adversely affect the rights of parties to those proceedings. At any time prior to the hearing, any party may on motion request that the matters not be consolidated, and the motion shall be granted for good cause shown.

b. Severance. The presiding officer may, upon motion by any party or upon the presiding officer’s own motion, for good cause shown, order any proceeding or portion thereof severed.

7.47(2) Presiding officer. Appeal hearings shall be conducted by an administrative law judge appointed by the department of inspections and appeals.

7.47(3) Rights of appellants during hearings. All rights afforded appellants at rule 441—7.8(17A) shall apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.48(17A) Appeal record.

7.48(1) The appeal record shall consist of all items specified in Iowa Code section 17A.16.

7.48(2) The party that requests a transcription of the proceedings shall bear the cost.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.49(17A) Pleadings.

7.49(1) Pleadings may be required by rule, by the notice of hearing or by order of the presiding officer.

7.49(2) Petition. When an action of the department is appealed and pleadings are required under subrule 7.49(1), the aggrieved party shall file the petition.

a. Any required petition shall be filed within 20 days of delivery of the notice of hearing, unless otherwise ordered.

b. The petition shall state in separately numbered paragraphs the following:

(1) On whose behalf the petition is filed;

(2) The particular provisions of the statutes and rules involved;

(3) The relief demanded and the facts and law relied upon for relief; and

(4) The name, address and telephone number of the petitioner and the petitioner’s attorney, if any.

7.49(3) Answer. If pleadings are required, the answer shall be filed within 20 days of service of the petition or notice of hearing, unless otherwise ordered.

a. Any party may move to dismiss or apply for a more definite, detailed statement when appropriate.

b. The answer shall show on whose behalf it is filed and specifically admit, deny or otherwise answer all material allegations of the pleading to which it responds. It shall state any facts deemed to show an affirmative defense and may contain as many defenses as the pleader may claim.

c. The answer shall state the name, address and telephone number of the person filing the answer and of the attorney representing that person, if any.

d. Any allegation in the petition not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer which could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

7.49(4) Amendment. Any notice of hearing, petition or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.50(17A) Ex parte communications. The rules regarding ex parte communications specified in subrule 7.9(1) and Iowa Code section 17A.17 apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.51(17A) Right of judicial review. The rules regarding right of judicial review specified in subrule 7.12(3) and Iowa Code section 17A.19 apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

These rules are intended to implement Iowa Code chapter 17A.
[Filed December 27, 1971; amended December 2, 1974]
[Filed 4/30/76, Notice 3/22/76—published 5/17/76, effective 7/1/76]
[Filed 9/29/76, Notice 8/23/76—published 10/20/76, effective 11/24/76]
[Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]
[Filed 5/8/78, Notice 10/19/77—published 5/31/78, effective 7/5/78]
[Filed emergency 3/30/79—published 4/18/79, effective 3/30/79]
[Filed 5/5/80, Notice 2/20/80—published 5/28/80, effective 7/2/80]
[Filed 6/2/81, Notice 3/18/81—published 6/24/81, effective 8/1/81]
[Filed 7/1/82, Notices 10/28/81, 12/23/81—published 7/21/82, effective 8/25/82]
[Filed 7/1/82, Notice 5/12/82—published 7/21/82, effective 9/1/82]
[Filed 10/28/83, Notice 8/17/83—published 11/23/83, effective 1/1/84]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 2/8/84]
[Filed 5/4/84, Notice 2/29/84—published 5/23/84, effective 7/1/84]
[Filed 5/4/84, Notice 3/14/84—published 5/23/84, effective 7/1/84]
[Filed 7/26/85, Notice 6/5/85—published 8/14/85, effective 10/1/85]
[Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 1/15/87, Notice 12/3/86—published 2/11/87, effective 4/1/87]
[Filed emergency 7/14/89 after Notice 5/31/89—published 8/9/89, effective 8/1/89]
[Filed 11/16/89, Notice 9/20/89—published 12/13/89, effective 2/1/90]
[Filed 1/16/90, Notice 11/15/89—published 2/7/90, effective 4/1/90]
[Filed emergency 10/10/91 after Notice 8/21/91—published 10/30/91, effective 11/1/91]
[Filed 1/16/92, Notice 9/18/91—published 2/5/92, effective 4/1/92]
[Filed 1/16/92, Notice 11/27/91—published 2/5/92, effective 4/1/92]
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed emergency 11/12/93—published 12/8/93, effective 1/1/94]
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed 10/12/94, Notice 8/17/94—published 11/9/94, effective 1/1/95]
[Filed without Notice 9/25/95—published 10/11/95, effective 12/1/95]
[Filed emergency 11/16/95—published 12/6/95, effective 12/1/95]
[Filed emergency 1/10/96 after Notice 10/11/95—published 1/31/96, effective 2/1/96]
[Filed 1/10/96, Notice 10/11/95—published 1/31/96, effective 4/1/96]
[Filed 8/15/96, Notice 5/8/96—published 9/11/96, effective 11/1/96]
[Filed 10/9/96, Notice 8/14/96—published 11/6/96, effective 1/1/97]
[Filed emergency 9/16/97—published 10/8/97, effective 10/1/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 12/10/97, Notice 10/8/97—published 12/31/97, effective 3/1/98]
[Filed 6/10/98, Notice 5/6/98—published 7/1/98, effective 8/5/98]
[Filed without Notice 6/10/98—published 7/1/98, effective 8/5/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 3/10/99, Notice 11/18/98—published 4/7/99, effective 5/31/99]
[Filed 9/12/00, Notice 7/12/00—published 10/4/00, effective 12/1/00]
[Filed 2/14/01, Notice 11/29/00—published 3/7/01, effective 5/1/01]
[Filed 5/9/01, Notice 2/21/01—published 5/30/01, effective 7/4/01]
[Filed 4/10/03, Notice 2/19/03—published 4/30/03, effective 7/1/03]
[Filed 9/22/03, Notice 7/23/03—published 10/15/03, effective 12/1/03]
[Filed emergency 10/10/03—published 10/29/03, effective 11/1/03]
[Filed 5/14/04, Notice 3/31/04—published 6/9/04, effective 7/14/04]
[Filed emergency 7/9/04—published 8/4/04, effective 7/9/04]
[Filed 9/23/04, Notice 8/4/04—published 10/13/04, effective 11/17/04]
[Filed emergency 2/10/05 after Notice 12/22/04—published 3/2/05, effective 3/1/05]
[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
[Filed 8/12/05, Notice 6/8/05—published 8/31/05, effective 11/1/05]
[Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
[Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
[Filed 11/16/05, Notice 9/14/05—published 12/7/05, effective 2/1/06]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
[Filed 10/20/06, Notice 8/30/06—published 11/8/06, effective 1/1/07]
[Filed emergency 11/9/06 after Notice 7/5/06—published 12/6/06, effective 12/1/06]
[Filed 3/14/07, Notice 8/30/06—published 4/11/07, effective 7/1/07]
[Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
[Filed emergency 12/11/08 after Notice 10/8/08—published 1/14/09, effective 2/1/09]
[Filed ARC 8003B (Notice ARC 7730B, IAB 4/22/09), IAB 7/29/09, effective 9/2/09]
[Filed ARC 8439B (Notice ARC 8083B, IAB 8/26/09), IAB 1/13/10, effective 3/1/10]
[Filed ARC 8994B (Notice ARC 8756B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10]
[Filed Emergency ARC 9254B, IAB 12/1/10, effective 1/1/11]
[Filed Emergency After Notice ARC 9698B (Notice ARC 9589B, IAB 6/29/11), IAB 9/7/11, effective 8/15/11]
[Filed ARC 0304C (Notice ARC 0132C, IAB 5/30/12), IAB 9/5/12, effective 11/1/12]
[Filed ARC 0487C (Notice ARC 0325C, IAB 9/5/12), IAB 12/12/12, effective 2/1/13]
[Filed ARC 0583C (Notice ARC 0435C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
[Filed ARC 0819C (Notice ARC 0671C, IAB 4/3/13), IAB 7/10/13, effective 9/1/13]
[Filed ARC 1206C (Notice ARC 1000C, IAB 9/4/13), IAB 12/11/13, effective 1/15/14]
[Filed ARC 1261C (Notice ARC 1129C, IAB 10/16/13), IAB 1/8/14, effective 3/1/14]
[Filed ARC 1478C (Notice ARC 1385C, IAB 3/19/14), IAB 6/11/14, effective 8/1/14]
[Filed ARC 1611C (Notice ARC 1515C, IAB 6/25/14), IAB 9/3/14, effective 11/1/14]
[Filed ARC 1694C (Notice ARC 1588C, IAB 8/20/14), IAB 10/29/14, effective 1/1/15]
[Filed ARC 3093C (Notice ARC 2972C, IAB 3/15/17), IAB 6/7/17, effective 7/12/17]
[Filed Emergency ARC 3199C, IAB 7/19/17, effective 7/1/17]
[Filed ARC 3389C (Notice ARC 3198C, IAB 7/19/17), IAB 10/11/17, effective 11/15/17]
[Filed ARC 3787C (Notice ARC 3652C, IAB 2/28/18), IAB 5/9/18, effective 7/1/18]
[Filed ARC 3871C (Notice ARC 3783C, IAB 5/9/18), IAB 7/4/18, effective 8/8/18]
[Filed ARC 4064C (Notice ARC 3907C, IAB 8/1/18), IAB 10/10/18, effective 12/1/18]
[Filed ARC 4972C (Notice ARC 4674C, IAB 9/25/19), IAB 3/11/20, effective 4/15/20]
[Filed ARC 5810C (Notice ARC 5549C, IAB 4/7/21), IAB 7/28/21, effective 9/1/21]
[Filed ARC 6384C (Notice ARC 6298C, IAB 4/20/22), IAB 6/29/22, effective 9/1/22]

0 Two or more ARCs
CHAPTER 13
PROGRAM EVALUATION

PREAMBLE

The purpose of this chapter is to define the methods and procedures used by the department to provide a systematic process for measuring the validity of the eligibility determinations in the family investment program (FIP), Supplemental Nutrition Assistance Program (SNAP), child care assistance program, and medical assistance program; to provide a basis for establishing state agency liability for errors; and to provide program information that can be used by the department in determining a corrective action plan to ensure the rules and regulations are implemented in accordance with the program rules.

[ARC 4750C; IAB 11/6/19, effective 12/11/19; ARC 6385C, IAB 6/29/22, effective 9/1/22]


“Active case” means a case that was receiving assistance for the month of review.

“Case record” means the record used to establish a client’s eligibility.

“Client” means a current or former applicant or recipient of the family investment program (FIP), Supplemental Nutrition Assistance Program (SNAP), child care assistance program, or medical assistance program.

“Department” means the Iowa department of human services.

“Field investigation” means a contact involving the public or other agencies to obtain information about the client’s circumstances for the appropriate month of review.

“Local agency” means the local or service area office of the department.

“Medical assistance programs” means those programs funded by Medicaid or the Children’s Health Insurance Program (CHIP).

“Month of review” means the specific calendar or fiscal month for which the assistance under review is received.

“Negative case” means a case that was terminated or denied assistance in the month of review.

“Public assistance programs” means those programs involving federal funds, i.e., family investment program (FIP), Supplemental Nutrition Assistance Program (SNAP), child care assistance program, and medical assistance program.

“Random sample” means a systematic (or every nth unit) sample drawn monthly for which each item in the universe has an equal probability of being selected. Sample size is determined by federal guidelines or state corrective action needs.

“State policies” means the rules and regulations used by the department to administer the family investment program (FIP), Supplemental Nutrition Assistance Program (SNAP), child care assistance program, and medical assistance program.

This rule is intended to implement Iowa Code sections 234.12, 239B.4, 249A.4 and 514I.4.

[ARC 4750C; IAB 11/6/19, effective 12/11/19; ARC 6385C, IAB 6/29/22, effective 9/1/22]

441—13.2(234,239B,249A,514I) Review of public assistance records by the department.

13.2(1) Authorized representatives of the department shall have the right to review case records to determine the following:

a. If the client has provided complete, correct and accurate information to the local agency to be used in the determination of the assistance benefits.

b. If the local agency has correctly administered the state policies in determination of assistance for the public assistance programs.

c. Whether overpayments or underpayments have been made correctly to the public assistance client during the month of review.

d. If there is indication of fraudulent practice or abuse of the public assistance programs by either the client or local agency.
13.2(2) All pertinent case records within the department may be used by the reviewer to assist in substantiating an accurate reflection as to the correctness of the assistance received by the client.

This rule is intended to implement Iowa Code sections 234.12, 239B.4, 249A.4 and 514I.4.

[ARC 4750C, IAB 11/6/19, effective 12/11/19]

441—13.3(234,239B,249A,514I) Who shall be reviewed. Any active or negative public assistance case may be reviewed at any time at the discretion of the department based upon a random sample to:

13.3(1) Ensure federal and state requirements for quality control are met.
13.3(2) Detect error prone case issues to assist in corrective action.
13.3(3) Maintain public assistance program integrity.

This rule is intended to implement Iowa Code sections 234.6, 234.12, 239B.4, 249A.4, and 514I.4.

[ARC 4750C, IAB 11/6/19, effective 12/11/19]

441—13.4(234,239B,249A,514I) Notification of review. On positive case actions, clients shall be notified, either orally or in writing, that their case has been selected for review when contact is required by federal guidelines, or when contact is allowed and additional information is required to complete the review. The client will be contacted in a negative case only if a discrepancy exists that cannot be resolved from the case record and contact is allowed by federal guidelines.

This rule is intended to implement Iowa Code sections 234.6, 234.12, 239B.4, 249A.4, and 514I.4.

[ARC 4750C, IAB 11/6/19, effective 12/11/19]

441—13.5(234,239B,249A,514I) Review procedure. The department will select the appropriate method of conducting the review. Review procedures may include, but are not limited to, the following:

13.5(1) A random sampling of active and negative case actions shall be used to determine the case records to be studied.
13.5(2) The case record shall be analyzed for discrepancies and correct application of policies and procedures and shall be used as the basis for a field investigation.
13.5(3) Client interviews shall be required as follows:
   a. Personal interviews are required on all active SNAP reviews.
   b. An appointment letter may be sent to the client on department letterhead to schedule or confirm the appointment date, time and location.
   c. Client contacts are only required in negative case reviews when there is a discrepancy that cannot be resolved from the case record.
13.5(4) Collateral contacts are made whenever the client is unable to furnish information needed or the reviewer needs additional information to establish the correctness of eligibility and payment but only when allowed by federal guidelines. Verification to confirm the accuracy of statements or information may be obtained by documentary evidence or a contact with a third party.
   a. The client shall be required to release specific information whenever necessary to verify information essential to the determination of eligibility and payment.
   b. Should the client refuse to authorize the department to contact an informant to verify information that is necessary for the completion of the review, collateral contacts shall still be made through use of the general release statement contained in the financial support application or the review/recertification eligibility document.

This rule is intended to implement Iowa Code sections 234.6, 234.12, 239B.4, 249A.4, and 514I.4.

[ARC 4750C, IAB 11/6/19, effective 12/11/19; ARC 6385C, IAB 6/29/22, effective 9/1/22]

441—13.6(234) Failure to cooperate. Client cooperation with quality control is a program eligibility requirement as set forth in rule 441—65.3(234). When quality control determines that the client has refused to cooperate with the review process, the client is no longer eligible for the program benefits and will not be eligible for the program benefits until the client has cooperated.

This rule is intended to implement Iowa Code section 234.12.

[ARC 4750C, IAB 11/6/19, effective 12/11/19]
441—13.7(234,239B,249A,514I) Report of findings. The quality control review findings are utilized by the department in the following ways:

13.7(1) The local agency will use the findings in taking the appropriate case actions where an overpayment or underpayment has been found in a client’s case record.

13.7(2) The department will use the overall findings to identify error-prone program issues to be used in planning its corrective action plan.

13.7(3) The department will use the findings of the overall sample period to determine the error rate used to establish state agency liability.

This rule is intended to implement Iowa Code sections 234.12, 239B.4, 249A.4, and 514I.4.

[ARC 4750C, IAB 11/6/19, effective 12/1/19]

441—13.8(234,237A,239B,249A,514I) Federal review. A sample of cases may also be reviewed by the applicable federal agency to determine the correctness of the department’s action or of the department’s review of the case.

This rule is intended to implement Iowa Code sections 234.12, 237A.12, 239B.4, 249A.4, and 514I.4.

[ARC 4750C, IAB 11/6/19, effective 12/1/19]

[Filed 3/26/87, Notice 1/28/87—published 4/22/87, effective 6/1/87]
[Filed emergency 10/10/03—published 10/29/03, effective 11/1/03]
[Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]

[Filed ARC 4750C (Notice ARC 4601C, IAB 8/14/19), IAB 11/6/19, effective 12/11/19]
[Filed ARC 6385C (Notice ARC 6283C, IAB 4/6/22), IAB 6/29/22, effective 9/1/22]
TITLE III
MENTAL HEALTH

CHAPTER 22
AUTISM SUPPORT PROGRAM

PREAMBLE

These rules provide for definitions of diagnostic and financial eligibility, provider qualifications, and appeal procedures related to the autism support program created in Iowa Code chapter 225D. The purpose of the autism support program is to provide funding for applied behavioral analysis services and care coordination for children with a diagnosis of autism who meet certain financial and clinical eligibility criteria.

[ARC 1329C; IAB 2/19/14, effective 4/1/14; ARC 6386C, IAB 6/29/22, effective 9/1/22]

441—22.1(225D) Definitions.

"Administrator" means the entity selected by the department through a request for proposal process or other contractual arrangement to administer the autism support program.

"Applicant" means an individual on whose behalf an application has been submitted but who has not been identified as an eligible individual, or an individual who has received a denial of eligibility for the program.

"Applied behavioral analysis" or "ABA" means the same as defined in Iowa Code section 225D.1.


"Autism service provider" means a person providing applied behavioral analysis, who meets both of the following criteria:

1. The person:
   - Is certified as a behavior analyst by the Behavior Analyst Certification Board, is a psychologist licensed under Iowa Code chapter 154B, or is a psychiatrist licensed under Iowa Code chapter 148; or
   - Is a board-certified assistant behavior analyst who performs duties, identified by and based on the standards of the Behavior Analyst Certification Board, under the supervision of a board-certified behavior analyst.

2. Is approved as a member of the provider network by the department.

"Autism support fund" or "fund" means the autism support fund created in Iowa Code section 225D.2.

"Autism support program" or "program" means the program created in Iowa Code section 225D.2 to provide funding for applied behavioral analysis and care coordination for eligible individuals with a diagnosis of autism.

"Clinically relevant" means medically necessary and resulting in the development, maintenance, or restoration, to the maximum extent practicable, of the functioning of an individual.

"Department" means the department of human services.

"Diagnostic assessment of autism" means medically necessary assessment, evaluations, or tests performed by a licensed child psychiatrist, developmental pediatrician, or clinical psychologist.

"Eligible individual" means a child less than 14 years of age who has been diagnosed with autism based on a diagnostic assessment of autism, is not otherwise eligible for coverage for applied behavioral analysis treatment or applied behavior analysis treatment under the medical assistance program, Iowa Code section 514C.28, Iowa Code section 514C.31, or private insurance coverage, and whose household income does not exceed 500 percent of the federal poverty level.

"Federal poverty level" means the most recently revised poverty income guidelines published by the United States Department of Health and Human Services.

"Household income" means household income, reported on the tax return on which the eligible individual is claimed as a dependent, as determined using the modified adjusted gross income methodology pursuant to Section 2002 of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148. If the eligible individual’s parents live together and file separate tax returns, the income reported on both parents’ tax returns must be combined.
“Household size” means the total number of personal and dependent exemptions claimed on the tax return on which the eligible individual is claimed as a dependent plus any child under the age of 19 living in the household who is claimed for tax purposes by a noncustodial parent through a release of claim to exemption by the custodial parent.

“Integrated health home” means the same as defined in 441—subrule 78.53(1).

“Maximum amount of treatment” means a maximum of 24 months of applied behavioral analysis funded by the autism support program. Months of service are not required to be consecutive.

“Maximum annual benefit” means a maximum annual benefit amount of $36,000 per year for autism support program services for an eligible individual. For the purposes of this program, the annual benefit is calculated by using as a starting date the date the first service is reimbursed by the program and an ending date 12 months from the starting date. Expenditures included in the calculation of the maximum annual benefit include reimbursements to autism service providers for provision of applied behavioral analysis and reimbursements to integrated health homes for costs of care coordination. Cost-sharing paid by the eligible individual is not included in the calculation of the individual’s annual benefit.

“Medical assistance” or “Medicaid” means assistance provided under the medical assistance program pursuant to Iowa Code chapter 249A and Title XIX of the Social Security Act.

“Month of service” means any month in which an individual receives at least one billable unit of applied behavioral analysis service funded by the autism support program.

“Provider network” means a network of autism service providers approved by the department to provide services to eligible individuals through the autism support program.

“Regional autism assistance program” or “RAP” means the regional autism assistance program created in Iowa Code section 256.35.

“Treatment plan” means a plan for the treatment of autism developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in consultation with the patient and the patient’s representative.

[ARC 1329C; IAB 2/19/14, effective 4/1/14; ARC 2816C, IAB 11/23/16, effective 1/1/17; ARC 3057C, IAB 5/10/17, effective 7/1/17; ARC 3788C, IAB 5/9/18, effective 7/1/18]

441—22.2(225D) Eligibility and application requirements. To be determined eligible for funding for services through the autism support program, an individual must meet the following requirements:

22.2(1) An individual shall submit an application to the department using a standardized application form available through the administrator’s and the department’s websites, members of the provider network, the regional autism assistance program, and advocacy organizations.

22.2(2) An applicant for autism program services shall be less than the age of 14 at the time of application for the program. Proof of age must be provided at the time of application. An individual who reaches the age of 14 prior to receipt of the maximum benefits of the program may continue to receive services from the program in accordance with the individual’s treatment plan, up to a maximum of 24 months of applied behavioral analysis treatment.

22.2(3) An individual shall have a diagnosis of autism based on a diagnostic assessment of autism dated 24 months or less from the date of application for the program.

22.2(4) An individual shall be determined ineligible for coverage of applied behavioral analysis services under the medical assistance program, Iowa Code section 514C.28, Iowa Code section 514C.31, or other private insurance coverage. Proof of insurance coverage and noneligibility for coverage for applied behavioral analysis shall be provided at the time of application and shall include a written denial of coverage or a benefits summary indicating that the applied behavioral analysis treatment or applied behavior analysis treatment is not a covered benefit for which the applicant is eligible under the Medicaid program, Iowa Code section 514C.28, Iowa Code section 514C.31, or other private insurance coverage.

22.2(5) An individual shall have a household income equal to or less than 500 percent of the federal poverty level. Information needed to determine household income using modified adjusted gross income methodology shall be identified on the program application. Household size will be determined according to the standards in this chapter. The information shall be provided at the time of application.
22.2(6) The department shall provide to the parent or guardian a written notice of decision determining initial eligibility or denial within 30 calendar days of receipt of the application.

22.2(7) The department shall refer an applicant determined to be an eligible individual to care coordination services. The referral will occur within 5 business days of determination of eligibility for the program. Care coordination services will be provided by the University of Iowa regional autism assistance program (RAP) or an integrated health home. Eligible individuals who reside in counties where integrated health homes for children with a serious emotional disturbance are operational may choose to receive care coordination through the University of Iowa RAP program or an integrated health home that serves residents of the eligible individual’s county of residence. Care coordination is not required as a condition of receiving services through the autism support program.

22.2(8) The department shall provide information to an applicant determined to be an eligible individual regarding all available administrators. The eligible individual may choose any available administrator.

22.2(9) The administrator shall maintain a list of individuals determined eligible for the program but unable to access services due to lack of available providers and shall work to connect eligible individuals on the list to network providers.

22.2(10) The department shall stop processing applications at the point where available funds are fully obligated for eligible individuals and additional eligible individuals would cause expenditures in excess of the funds available to the program. The department shall maintain a waiting list of individuals denied access to the program due to lack of available funds. If additional funds become available, the department shall contact individuals on the list in order of the earliest date and time of the receipt of the original application. The applicant shall be allowed 30 calendar days to submit an updated application and any required information needed to determine eligibility. If the applicant does not submit required information, the applicant will be denied eligibility and removed from the waiting list maintained for individuals denied access to the program due to lack of funding. The age of the applicant at the time of the most recent application will be used when determining eligibility for the program.

[ARC 1329C, IAB 2/19/14, effective 4/1/14; ARC 2816C, IAB 11/23/16, effective 1/1/17; ARC 3788C, IAB 5/9/18, effective 7/1/18]

441—22.3(225D) Cost-sharing requirements and graduated schedule of cost sharing.

22.3(1) An individual with a household income equal to or greater than 200 percent of the federal poverty level, up to a maximum of 500 percent of the federal poverty level, shall be subject to cost-sharing requirements. Cost sharing shall be implemented incrementally up to a maximum of 15 percent of the costs of the services provided through the program for an individual with a household income equal to 500 percent of the federal poverty level. The following is a chart of the cost-sharing requirements:

<table>
<thead>
<tr>
<th>Family income as a % of FPL</th>
<th>% of cost sharing of service costs</th>
<th>Family income as a % of FPL</th>
<th>% of cost sharing of service costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>200–209%</td>
<td>0.5%</td>
<td>350–359%</td>
<td>8.0%</td>
</tr>
<tr>
<td>210–219%</td>
<td>1.0%</td>
<td>360–369%</td>
<td>8.5%</td>
</tr>
<tr>
<td>220–229%</td>
<td>1.5%</td>
<td>370–379%</td>
<td>9.0%</td>
</tr>
<tr>
<td>230–239%</td>
<td>2.0%</td>
<td>380–389%</td>
<td>9.5%</td>
</tr>
<tr>
<td>240–249%</td>
<td>2.5%</td>
<td>390–399%</td>
<td>10.0%</td>
</tr>
<tr>
<td>250–259%</td>
<td>3.0%</td>
<td>400–409%</td>
<td>10.5%</td>
</tr>
<tr>
<td>260–269%</td>
<td>3.5%</td>
<td>410–419%</td>
<td>11.0%</td>
</tr>
<tr>
<td>270–279%</td>
<td>4.0%</td>
<td>420–429%</td>
<td>11.5%</td>
</tr>
<tr>
<td>280–289%</td>
<td>4.5%</td>
<td>430–439%</td>
<td>12.0%</td>
</tr>
</tbody>
</table>
22.3(2) An individual may request an exemption from cost sharing due to financial hardship. To qualify for an exemption, an individual shall submit written documentation to the department that the individual or the individual’s family does not have the financial means to fulfill cost-sharing requirements.

22.3(3) Criteria to determine financial hardship include, but are not limited to, a change in income, change in employment of the parent or guardian, additional medical expenditures, other family members’ health conditions, or other conditions which may affect the ability to fulfill cost-sharing requirements. The department shall provide a written determination regarding eligibility for exemption from cost-sharing requirements. Eligibility for exemption from cost sharing expires at the end of the financial eligibility period.

[ARC 1329C, IAB 2/19/14, effective 4/1/14; ARC 2816C, IAB 11/23/16, effective 1/1/17]

<table>
<thead>
<tr>
<th>Family income as a % of FPL</th>
<th>% of cost sharing of service costs</th>
<th>Family income as a % of FPL</th>
<th>% of cost sharing of service costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>290–299%</td>
<td>5.0%</td>
<td>440–449%</td>
<td>12.5%</td>
</tr>
<tr>
<td>300–309%</td>
<td>5.5%</td>
<td>450–459%</td>
<td>13.0%</td>
</tr>
<tr>
<td>310–319%</td>
<td>6.0%</td>
<td>460–469%</td>
<td>13.5%</td>
</tr>
<tr>
<td>320–329%</td>
<td>6.5%</td>
<td>470–479%</td>
<td>14.0%</td>
</tr>
<tr>
<td>330–339%</td>
<td>7.0%</td>
<td>480–489%</td>
<td>14.5%</td>
</tr>
<tr>
<td>340–349%</td>
<td>7.5%</td>
<td>490–500%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>

441—22.4(225D) Review of financial eligibility, cost-sharing requirements, exemption from cost sharing, and disenrollment in the program.

22.4(1) An eligible individual’s continued financial eligibility for the program, cost-sharing requirements, and exemption from cost sharing shall be determined on an annual basis.

22.4(2) The administrator shall request needed information from the eligible individual’s parent or guardian for redetermination of financial eligibility, cost-sharing requirements, and exemption from cost sharing at least 30 days prior to the expiration of the eligible individual’s eligibility period. The notice requesting information needed for renewal of eligibility shall include the ending date of eligibility for services.

22.4(3) The department shall provide a written notice of decision determining ongoing eligibility or denial within 15 calendar days of receipt of the continued financial eligibility documentation.

22.4(4) If the signed application and verification of continuing eligibility are not received by the department by the last working day of the renewal month, the individual’s eligibility for the program shall be terminated.

22.4(5) Reasons for disenrollment in the autism support program include:

a. Death of the eligible individual.

b. The family no longer meets one or more of the eligibility criteria outlined in rule 441—22.2(225D).

c. The parent or legal guardian has failed to provide information required for redetermination of eligibility.

d. The eligible individual has failed to access authorized services for a period of three consecutive months and has not made arrangements with the autism service provider or administrator to access authorized services.

e. No funds are appropriated for the autism support program.

[ARC 1329C, IAB 2/19/14, effective 4/1/14; ARC 2816C, IAB 11/23/16, effective 1/1/17]

441—22.5(225D) Initial service authorization and renewal of service authorization.

22.5(1) All services reimbursed through the program shall be prior-authorized by the administrator.

22.5(2) An autism service provider shall submit an initial treatment plan to the administrator specifying a plan of treatment for a period of no more than six months. The initial treatment plan shall
specify the amount of units of applied behavioral analysis services requested for the eligible individual and include a baseline standardized assessment score.

22.5(3) Family engagement and participation are required for participation in the autism support program. Treatment plans shall identify specific activities and responsibilities of parents or guardians in the treatment plan.

22.5(4) The treatment plan shall reflect the autism service provider’s engagement with the school in which the eligible individual is enrolled. Treatment plans shall identify specific actions taken by the autism service provider to engage the eligible individual’s school and the results of such actions.

22.5(5) The treatment plan may include services provided by staff with a minimum of a bachelor’s degree in a human services or education field, working under the supervision of an autism service provider who is board-certified as a behavior analyst. The treatment plan shall identify which services shall be provided directly by the board-certified behavior analyst and which services shall be provided by staff under the supervision of a board-certified behavior analyst.

22.5(6) For renewal or modification of service authorizations, the autism service provider shall submit an updated plan of treatment with a request for the number of units of applied behavioral analysis the provider believes is medically necessary to address the eligible individual’s ongoing treatment needs. The autism service provider shall also provide evidence of the eligible individual’s progress on identified treatment goals. The administrator shall consider the eligible individual’s updated standardized assessment score along with other clinical information when reviewing requests for renewal or modification of service authorizations. Ongoing service authorization requests shall not exceed six months in duration.

22.5(7) The administrator shall provide approval, request for modification, or denial within five business days of receipt of all service authorization requests.

[ARC 1329C; IAB 2/19/14, effective 4/1/14; ARC 2816C; IAB 11/23/16, effective 1/1/17]

441—22.6(225D) Provider network. The administrator shall establish and maintain a network of department-approved autism service providers so that applied behavioral analysis services are available to eligible individuals statewide to the maximum extent possible.

22.6(1) A provider shall be approved to participate in the autism support program provider network if the provider meets one of the following standards in paragraph 22.6(1) “a,” “b” or “c”:

a. The autism service provider is certified as a behavior analyst by the Behavior Analyst Certification Board; or

b. The autism service provider is a psychologist licensed under Iowa Code chapter 154B; or

c. The autism service provider is a psychiatrist licensed under Iowa Code chapter 148; and

d. A provider shall be deemed eligible to participate in the autism support program provider network if the autism service provider meets the standards in paragraph 22.6(1) “a,” “b” or “c” and the provider is approved to provide applied behavioral analysis services through Medicaid.

22.6(2) The administrator’s provider network shall accept the rate established by the department through the department’s contract with the administrator as payment in full for the services rendered and will not charge eligible individuals any additional fees for services rendered, except for those eligible individuals who are required to pay a portion of the cost of services due to cost-sharing requirements.

22.6(3) The department is responsible for calculating the cost-sharing amount according to standards established in this chapter.

22.6(4) The autism service provider is responsible for collecting the cost-sharing amount from the eligible individual and will only be reimbursed by the administrator for the balance of the service fee minus the amount of cost sharing.

[ARC 1329C; IAB 2/19/14, effective 4/1/14; ARC 2816C; IAB 11/23/16, effective 1/1/17]

441—22.7(225D) Financial management of the program.

22.7(1) The department shall:

a. Not take new applications for the program that would cause expenditures of the program to exceed the budgeted amount.
b. Limit expenditure of program funds to services for those individuals determined to be eligible individuals and for related administrative costs.

c. Allocate available funds for eligible individuals’ services in a manner that allows for funding for all eligible individuals’ services authorized by the administrator without exceeding the department’s funding limits.

22.7(2) The administrator shall:

a. Limit annual expenditures for each eligible individual to the amount identified in Iowa Code section 225D.2(2) “a.”

b. Limit length of service through the program to the amount identified in Iowa Code section 225D.2(2) “b.”

c. Limit payment for applied behavioral analysis services to an hourly or equivalent quarter-hour unit rate that is equal to the contracted rate currently paid by Medicaid for applied behavioral analysis services.

d. Limit payment for integrated health home services to an amount consistent with the monthly per-member per-month amount paid by Medicaid to approved providers of integrated health home services for children with a serious emotional disturbance.

e. Not provide financial compensation to the University of Iowa regional autism assistance program for care coordination services.

[ARC 1329C; IAB 2/19/14, effective 4/1/14; ARC 2816C, IAB 11/23/16, effective 1/1/17]

441—22.8(225D) Appeal. Notice of adverse action shall be given in accordance with 441—Chapter 16. The right to appeal shall be given in accordance with 441—Chapter 7.

[ARC 1329C, IAB 2/19/14, effective 4/1/14; ARC 6386C, IAB 6/29/22, effective 9/1/22]

These rules are intended to implement Iowa Code chapter 225D.

[Filed ARC 1329C (Notice ARC 1184C, IAB 11/13/13), IAB 2/19/14, effective 4/1/14]
[Filed ARC 2816C (Notice ARC 2680C, IAB 8/17/16), IAB 11/23/16, effective 1/1/17]
[Filed ARC 3057C (Notice ARC 2971C, IAB 3/15/17), IAB 5/10/17, effective 7/1/17]
[Filed ARC 3788C (Notice ARC 3619C, IAB 2/14/18), IAB 5/9/18, effective 7/1/18]
[Filed ARC 6386C (Notice ARC 6299C, IAB 4/20/22), IAB 6/29/22, effective 9/1/22]
CHAPTER 57
INTERIM ASSISTANCE REIMBURSEMENT
[Prior to 2/11/87, Human Services[498]]

441—57.1(249) Definitions.

“Benefits” means Supplemental Security Income (SSI) for the aged, blind, and disabled (a federal cash assistance program under Title XVI of the Social Security Act) and any federally administered state supplementary assistance payments that are determined by the Social Security Administration to be due an individual at the time the SSI payment is made.

“County agency” means a county or county subdivision under the jurisdiction of the county board of supervisors, including a county commission of veteran affairs, that furnishes relief in the form of cash or vendor payments to or in behalf of needy persons in accordance with established standards under the provisions of Iowa Code chapter 35B or 252.

“Initial payment” means the amount of benefits determined by the Social Security Administration to be payable to an eligible person (including any retroactive amounts) when the person is first determined to be eligible for SSI. The initial payment does not include any emergency advance payments, any presumptive disability or blindness payments, or any immediate payments authorized under Section 1631 of the Social Security Act.

“Initial posteligibility payment” means the amount of benefits determined by the Social Security Administration to be payable to an eligible person (including any retroactive amounts) when the person is first determined eligible for SSI following a period of suspension or termination. The initial posteligibility payment does not include any emergency advance payments, any presumptive disability or blindness payments, or any immediate payments authorized under Section 1631 of the Social Security Act.

“Interim assistance” means assistance in the form of cash or vendor payments for meeting basic needs furnished by a county agency during the interim period. Basic needs include food, clothing, shelter, medical care and services not covered by Medicaid, and other essentials of daily living. Interim assistance does not include the county payment of social services costs associated with services during the interim period or medical care or services covered by Medicaid.

“Interim period” means either (1) the period beginning with the month following the month in which a person filed an application for benefits for which the person was found to be eligible and ending with and including the month the person’s benefits began, or (2) the period beginning the day the person’s benefits were reinstated after a period of suspension or termination, and ending with (and including) the month the person’s benefits were resumed. The interim period does not include any periods during which the person is underpaid by the Social Security Administration due to that agency’s failure to make a timely modification of the person’s SSI benefit or for any other reason.

[ARC 8990B, IAB 8/11/10, effective 9/15/10; ARC 9174B, IAB 11/3/10, effective 12/8/10]

441—57.2(249) Requirements for reimbursement. In order to receive reimbursement for interim assistance payments, a county agency must meet the following requirements.

57.2(1) Agreement. The county agency shall enter into a written agreement with the department of human services on Form 470-1948.

57.2(2) Authorization. The county agency shall secure written authorization from the person seeking interim assistance. By signing Form 470-1950, the person:

a. Indicates the intent to apply for SSI benefits.

b. Authorizes the Social Security Administration to:

(1) Withhold the amount of interim assistance from the person’s initial payment or initial posteligibility payment, and

(2) Make this amount payable to the county agency.

57.2(3) Records. The county agency shall:

a. Maintain a file for each person who has received interim assistance.

b. Maintain adequate records of all transactions made relating to interim assistance.
c. Comply with the provisions of the Federal Information Security Management Act (FISMA); 20 CFR Part 401 as amended to April 1, 2009; and the Privacy Act of 1974 relating to the safeguarding of information concerning individuals who have applied for interim assistance.

[ARC 8990B, IAB 8/11/10, effective 9/15/10; ARC 9174B, IAB 11/3/10, effective 12/8/10; ARC 6387C, IAB 6/29/22, effective 9/1/22]

**441—57.3(249) Certificate of authority.**

57.3(1) The county agency shall submit the information requested on Form 470-1947 to the Social Security Administration at the address given on the form:
   a. Before the date the agency first participates in the program, and
   b. Subsequently when changes in the list of authorized officials occur.

57.3(2) The county agency shall submit a copy of Form 470-1947 to the department of human services at the address given on the form each time the form is submitted to the Social Security Administration.

[ARC 8990B, IAB 8/11/10, effective 9/15/10; ARC 9174B, IAB 11/3/10, effective 12/8/10; ARC 6387C, IAB 6/29/22, effective 9/1/22]

These rules are intended to implement 1984 Iowa Acts, chapter 1310, section 9.

[Filed without Notice 9/7/84—published 9/26/84, effective 11/1/84]
[Filed 11/16/84, Notice 9/26/84—published 12/5/84, effective 2/1/85]
[Filed 9/26/86, Notice 8/13/86—published 10/22/86, effective 12/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 1/12/89—published 2/8/89, effective 1/12/89]
[Filed 3/15/89, Notice 2/8/89—published 4/5/89, effective 6/1/89]
[Filed without Notice 9/18/91—published 10/16/91, effective 11/21/91]
[Filed emergency 10/10/91—published 10/30/91, effective 11/21/91]
[Filed 1/29/92, Notice 10/16/91—published 2/19/92, effective 3/25/92]
[Filed 4/14/94, Notice 2/16/94—published 5/11/94, effective 7/1/94]
[Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02]
[Filed Without Notice ARC 8990B, IAB 8/11/10, effective 9/15/10]
[Filed ARC 9174B (Notice ARC 8991B, IAB 8/11/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 6387C (Notice ARC 6297C, IAB 4/20/22), IAB 6/29/22, effective 9/1/22]
CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS
OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]
[Prior to 2/11/87, Human Services[498]]

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.2(249A) Retail pharmacies. Retail pharmacies are eligible to participate if they meet the requirements of this rule.

77.2(1) Licensure. Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

77.2(2) Survey participation. As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

a. A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

b. A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

c. Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy’s individual costs shall be held confidential.

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

[ARC 0485C, IAB 12/12/12, effective 2/1/13; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.3(249A) Hospitals.

77.3(1) Qualifications. All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

77.3(2) Referral to health home services provider. As a condition of participation in the medical assistance program, hospitals must establish procedures for referring to health home services providers any members who seek or need treatment in the hospital emergency department and who are eligible for health home services pursuant to 441—subrule 78.53(2).

77.3(3) Psychiatric bed tracking system. As a condition of participation in the medical assistance program, hospitals must establish procedures for participating in and updating the statewide psychiatric bed tracking system.

a. Definitions.

“Adult beds” means the number of staffed and available psychiatric beds ready for admission to individuals 18 years of age to 60 years of age.

“Child beds” means the number of staffed and available psychiatric beds ready for admission to individuals up to the age of 18.

“Gender” means female or male.

“Geriatric beds” means the number of staffed and available psychiatric beds ready for admission to individuals 60 years of age and older.
“Hospital,” for purposes of this subrule, means any licensed hospital providing inpatient psychiatric services and the state mental health institutes.

“Psychiatric bed tracking system” means a web-based electronic system managed by the department that can be searched to locate inpatient psychiatric services at an Iowa hospital.

b. Hospitals are required to participate in the psychiatric bed tracking system.

c. Hospitals shall update the psychiatric bed tracking system, at a minimum, two times per day. The first update shall be entered between 12:00:01 a.m. and 9:59:59 a.m. each day; the second update shall be entered between 8:00:00 p.m. and 11:59:59 p.m. each day.

d. Each update must include the number of child beds by gender, the number of adult beds by gender, and the number of geriatric beds by gender.

e. Failure to comply with the psychiatric bed tracking reporting may result in sanctions in accordance with rule 441—79.2(249A).

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

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 3789C, IAB 5/9/18, effective 7/1/18]

441—77.4(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES — Payment will not be made to a dental laboratory.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.5(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.6(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.7(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.8(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

77.9(1) Definitions.
"Assets" includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

"Rider" means a notice issued by a surety that a change in the bond has occurred or will occur.

"Uncollected overpayment" means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.9(2) Parties to surety bonds. The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety’s name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company’s liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.9(3) Surety company obligations. The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.9(4) Surety bond requirements. Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. Effective dates and submission dates.

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency’s fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency’s fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency’s fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.
(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

b. **Amount of bond.** Bonds for any period shall be in the amount of $50,000 or 15 percent of the home health agency’s annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of $50,000. At least 90 days before the start of each home health agency’s fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

c. **Other requirements.** Surety bonds shall meet the following additional requirements. The bond shall:

1. Guarantee that upon written demand by the department to the surety for payment under the bond and the department’s furnishing to the surety sufficient evidence to establish the surety’s liability under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

2. Provide that the surety’s liability for uncollected overpayments is based on overpayments determined during the term of the bond.

3. Provide that the surety’s liability to the department is not extinguished by any of the following:
   1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.
   2. The surety’s failure to continue to meet the requirements in subrule 77.9(2) or the department’s determination that the surety company is an unauthorized surety under subrule 77.9(2).
   3. Termination of the home health agency’s provider agreement.
   4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.
   5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.
   6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety’s agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety’s agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety’s liability to the department to exceed the amount of the bond.
   7. The home health agency’s failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

4. Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency’s provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

5. Provide that actions under the bond may be brought by the department or by an agent designated by the department.

6. Provide that the surety may appeal department decisions.

77.9(5) **Exemption from surety bond requirements for government-operated home health agencies.** A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.
**77.9(6) Government-operated home health agency that loses its exemption.** A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department’s written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

**441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies.** All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

**441—77.11(249A) Ambulance service.** Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

**441—77.12(249A) Behavioral health intervention.** A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC), or

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

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 6310C, IAB 5/4/22, effective 7/1/22]

**441—77.13(249A) Hearing aid dispensers.** Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

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

**441—77.14(249A) Audiologists.** Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

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

**441—77.15(249A) Community mental health centers.** Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

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

**441—77.16(249A) Screening centers.** Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health’s standards for a child health screening center. The staff members must be employed by or under contract with
the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

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

441—77.17(249A) **Physical therapists.** Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

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

441—77.18(249A) **Orthopedic shoe dealers and repair shops.** Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

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

441—77.19(249A) **Rehabilitation agencies.** Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

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

441—77.20(249A) **Independent laboratories.** Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians’ offices, hospitals, and critical access hospitals.

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

441—77.21(249A) **Rural health clinics.** Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.22(249A) **Psychologists.**

77.22(1) All psychologists licensed to practice in the state of Iowa and meeting the current credentialing requirements of the National Register of Health Service Psychologists are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the current credentialing requirements of the National Register of Health Service Psychologists.

77.22(2) A psychologist provisionally licensed to practice in the state of Iowa pursuant to Iowa Code section 154B.6 is eligible to participate in the medical assistance program when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist.

77.22(3) A psychologist provisionally licensed in another state is eligible to participate when the person:

a. Possesses a doctoral degree in psychology from an institution approved by the board of psychology; and

b. Provides treatment under the supervision of a licensed psychologist pursuant to Iowa Code section 154B.6. Claims for payment for such services must be submitted by the licensed psychologist who is duly licensed to practice in that state.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

[ARC 2165C, IAB 9/30/15, effective 12/1/15; ARC 4165C, IAB 12/5/18, effective 1/9/19]
441—77.23(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor’s degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

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

441—77.24(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall meet the general requirements in subrules 77.25(2), 77.25(3), 77.25(4), and 77.25(5) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.25(1) Definitions.

“Certified employment specialist” or “CES” means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

“Guardian” means a guardian appointed in probate or juvenile court.

“Individual placement and support” or “IPS” means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center at Westat, and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition_2-4-16.pdf. The IPS practice principles are:

1. Focus on competitive employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.

2. Zero exclusion criteria based on client choice: People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

3. Integration of rehabilitation and mental health services: IPS programs are closely integrated with mental health treatment teams.

4. Attention to worker preferences: Services are based on each person’s preferences and choices, rather than providers’ judgments.

5. Personalized benefits counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their social security, Medicaid, and other government entitlements.

6. Rapid job search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy preemployment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.

7. Systematic job development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.

8. Time-unlimited and individualized support: Job supports are individualized and continue for as long as each worker wants and needs the support.
“Intensive residential service homes” or “intensive residential services” means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation or HCBS intellectual disability waiver supported community living and meet additional criteria specified in 441—subrule 25.6(8).

“IPS 25-item supported employment fidelity scale” means the fidelity scale published by the IPS Employment Center at Westat, resulting in scores of exemplary fidelity, good fidelity, fair fidelity, or not supported employment.

“IPS implementation” means the process advocated by the IPS Employment Center at Westat, which consists of the following phases:

1. Formation of IPS team steering group and one-day meeting with the IPS trainer and team members.
2. Completion of the IPS Readiness Assessment developed by the IPS Employment Center at Westat and individual review with the IPS trainer.
3. Completion of a one-day IPS kick-off team training with the IPS trainer and team members.
4. Participation in individual team training and monthly consultations as follows:
   • Two-and-a-half-day individual team training with the IPS trainer and team members.
   • Virtual training by the IPS Employment Center at Westat for at least three people per team.
   • Leadership training for two people per team at the IPS Employment Center at Westat.
   • Virtual monthly technical assistance for two hours per month per team.
5. Participation in the International Learning Collaborative, including:
   • Participation in the International Learning Collaborative annual conference by two people per state.
   • Virtual monthly technical assistance calls with the IPS Employment Center at Westat mentor assigned to the team.
   • Participation in the prescribed data tracking and management activities.
6. Completion of one baseline fidelity review per IPS team, with two IPS reviewers on site for two days per review.
7. Evaluation and development of next steps, with an on-site half-day meeting for the IPS trainer and the team.

“IPS reviewer” means a person who is qualified to complete fidelity reviews of IPS services and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa which has obtained a fidelity score of “good” or better, has completed the IPS Employment Center at Westat’s training to become an IPS reviewer, and has shadowed one or more IPS fidelity reviews;
2. An existing IPS reviewer from a state which is a member of the IPS International Learning Collaborative;
3. An IPS reviewer contracted directly from the IPS Employment Center at Westat;
4. A CES with a bachelor’s degree who has completed the IPS Employment Center at Westat’s training to become an IPS reviewer and has shadowed one or more IPS fidelity reviews.

“IPS team” means, at a minimum, an IPS employment specialist, a behavioral health specialist, Iowa Vocational Rehabilitation Services (IVRS) counselor, and a case manager or care coordinator.

“IPS trainer” means a person who is qualified to provide training and technical assistance for IPS implementation and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa which has obtained a fidelity score of “good” or better, and has completed the IPS Employment Center at Westat’s training to become an IPS trainer;
2. An existing IPS trainer from a state which is a member of the IPS International Learning Collaborative;
3. An IPS trainer contracted directly from the IPS Employment Center at Westat;
4. A CES with a bachelor’s degree who has completed the IPS Employment Center at Westat’s training to become an IPS trainer.

“Major incident” means an occurrence involving a member during service provision that:
1. Results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a member’s location being unknown by provider staff who are assigned protective oversight.

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

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

“Minor incident” means an occurrence involving a member during service provision that is not a major incident and that:
1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

“Prospective IPS team” means a group that is forming an IPS team to deliver IPS services but who has not yet completed implementation phase 4a.

“Provider-owned or controlled setting” means a setting where the HCBS provider owns the property where the member resides, leases the property from a third party, or has a direct or indirect financial relationship with the property owner that impacts either the care provided to or the financial conditions applicable to the member. The unit or dwelling is a specific physical space that can be owned, rented, or occupied under a legally enforceable agreement by the member receiving services, and the member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For the settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS member and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction’s landlord tenant law.

“Provisionally approved IPS team” means a group that has (1) formed a team to deliver IPS services, (2) completed implementation phase 4a, and (3) begun to deliver IPS services.

77.25(2) Organization and staff.

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.25(3) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa
Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent abuse and
with the incident management and reporting requirements in this subrule.

a. Reporting procedure for minor incidents. Minor incidents may be reported in any format
designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor
incident, the staff member involved shall submit the completed incident report to the staff member’s
supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized
file with a notation in the member’s file.

b. Reporting procedure for major incidents. When a major incident occurs or a staff member
becomes aware of a major incident:

   (1) The staff member involved shall notify the following persons of the incident by the end of the
       next calendar day after the incident:
       1. The staff member’s supervisor.
       2. The member or the member’s legal guardian. EXCEPTION: Notification to the member is
          required only if the incident took place outside of the provider’s service provision. Notification to the
          guardian, if any, is always required.
       3. The member’s case manager.

   (2) By the end of the next calendar day after the incident, the staff member who observed or first
       became aware of the incident shall also report as much information as is known about the incident to
       the member’s managed care organization in the format defined by the managed care organization. If the
       member is not enrolled with a managed care organization, the staff member shall report the information
       to the department’s bureau of long-term care either:
       1. By direct data entry into the Iowa Medicaid Provider Access System, or
       2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on
          the form.

       (3) The following information shall be reported:
       1. The name of the member involved.
       2. The date and time the incident occurred.
       3. A description of the incident.

       (4) The names of all provider staff and others who were present at the time of the incident or who
       responded after becoming aware of the incident. The confidentiality of other members or nonmembers
       who were present must be maintained by the use of initials or other means.
       4. The action that the provider staff took to manage the incident.
       5. The resolution of or follow-up to the incident.

       (4) The date the report is made and the handwritten or electronic signature of the person making
       the report.

       (4) Submission of the initial report will generate a workflow in the Individualized Services
       Information System (ISIS) for follow-up by the case manager. When complete information about the
       incident is not available at the time of the initial report, the provider must submit follow-up reports until
       the case manager is satisfied with the incident resolution and follow-up. The completed report shall be
       maintained in a centralized file with a notation in the member’s file.

   c. Tracking and analysis. The provider shall track incident data and analyze trends to assess
   the health and safety of members served and determine if changes need to be made for service
   implementation or if staff training is needed to reduce the number or severity of incidents.

77.25(4) Restraint, restriction, and behavioral intervention. The provider shall have in place a
system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral
intervention procedures. All members receiving home- and community-based habilitation services
shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral
intervention is implemented.

   a. The system shall include procedures to inform the member and the member’s legal guardian of
the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval
and as changes occur.
b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member’s restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.25(5) Residential and nonresidential settings. Effective March 17, 2022, all home- and community-based services (HCBS), whether residential or nonresidential, shall be provided in integrated, community-based settings that support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. Settings shall optimize individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.

a. Nursing facilities, institutions for mental diseases, intermediate care facilities for persons with an intellectual disability, and hospitals are not considered integrated, community-based settings.

b. Any HCBS setting that is located in a building that is also a publicly or privately operated facility, identified in paragraph 77.25(5) “a.” that provides inpatient treatment or in a building on the grounds of, or immediately adjacent to, a public institution, identified in paragraph 77.25(5) “a.” or any setting that has the effect of isolating members receiving Medicaid HCBS from the broader community will be presumed to be a setting that has the qualities of an institution unless the department conducts a site-specific review and determines otherwise.

c. Residential services may be provided in provider-owned or controlled settings. In provider-owned or controlled residential settings:

(1) The member selects the setting from among setting options, including non-disability-specific settings and an option for a private unit in a residential setting.

(2) The setting options are identified and documented in the person-centered service plan and are based on the member’s needs, preferences, and resources available for room and board.

(3) Members have choices regarding services and supports received and who provides them.

(4) Members are assured the rights of privacy, dignity, respect, and freedom from coercion and undue restraint.

(5) Services and supports shall optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact.

(6) Each member shall be afforded privacy in the member’s sleeping and living unit. Living unit entrance doors and bedroom doors may be locked by the member, and only appropriate staff shall have keys. Staff access to keys must be identified in the member’s person-centered plan.

(7) Members shall have a choice of roommates in that setting.

(8) Members shall have the freedom to furnish and decorate their sleeping or living areas as desired as permitted by any operative lease or other agreement.

(9) Members shall have the freedom and support to control their own schedules and activities and shall have access to food at any time.

(10) Members may have visitors of their choosing at any time.

(11) The setting shall be physically accessible to the member.

77.25(6) Case management. A provider is eligible to participate in the home- and community-based habilitation services program as a provider of case management services if accredited as a case management provider pursuant to 441—Chapter 24.

77.25(7) Day habilitation.

a. The following providers may provide day habilitation:
(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

(2) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency’s last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under subparagraph 77.25(7) “a”(1), 77.25(7) “a”(4), or 77.25(7) “a”(7).

(3) An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

(5) An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

(6) An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

(7) An agency that is accredited by the International Center for Clubhouse Development.

(8) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

b. Direct support staff providing day habilitation services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent degree. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within six months of hire or within six months of February 1, 2021, complete at least 9.5 hours of training in supporting members in the activities listed in 701—paragraph 78.27(8) “a,” as offered through DirectCourse or Relias or other nationally recognized training curriculum.

(4) A person providing direct support shall annually complete 4 hours of continuing education in supporting members in the activities listed in 701—paragraph 78.27(8) “a,” as offered through DirectCourse or Relias or other nationally recognized training curriculum.

77.25(8) Home-based habilitation.

a. The following agencies may provide home-based habilitation services:

(1) An agency that is certified by the department to provide supported community living services under:

1. The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or
2. The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

(2) An agency that is accredited under 441—Chapter 24 to provide supported community living services.

(3) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

(5) An agency that is accredited by the Council on Accreditation of Services for Families and Children.

(6) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.
b. Direct support staff providing home-based habilitation services shall meet the following minimum qualifications in addition to the other requirements outlined in this rule:
   (1) A person providing direct support shall be at least 18 years old and have a high school diploma or its equivalent.
   (2) A person providing direct support shall not be an immediate family member of the member receiving services.
   (3) A person providing direct support to members receiving intensive residential habilitation services shall complete 48 hours of training within the first year of employment and 24 hours of training each year thereafter in mental health and multi-occurring conditions pursuant to 441—subrule 25.6(8).
   (4) A person providing direct support to members receiving home-based habilitation services shall complete a minimum of 24 hours of training within the first year of employment in mental health and multi-occurring conditions, including but not limited to the following topics:
      1. Mental health diagnoses, symptomology, and treatment;
      2. Intervention strategies that may include applied behavioral analysis, motivational interviewing, or other evidence-based practices;
      3. Crisis management, intervention, and de-escalation;
      4. Psychiatric medications, common medications, and potential side effects;
      5. Member-specific medication protocols, supervision of self-administration of medication, and documentation;
      6. Substance use disorders and treatment;
      7. Other diagnoses or conditions present in the population served; and
      8. Individual-person-centered service plan, crisis plan, and behavioral support plan implementation.
   (5) A person providing direct support to members receiving home-based habilitation services shall complete a minimum of 12 hours of training annually on the topics listed in subparagraph 77.25(8)“(4)” or other topics related to serving individuals with severe and persistent mental illness.
   c. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.
   d. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:
      (1) Approval will not result in an overconcentration of supported community living units in a geographic area; and
      (2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:
         1. The quantity of services currently available in the county is insufficient to meet the need; or
         2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
         3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.25(9) Prevocational habilitation.
   a. The following providers may provide prevocational services:
      (1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.
      (2) An agency that is accredited by the Council on Quality and Leadership.
      (3) An agency that is accredited by the International Center for Clubhouse Development.
      (4) An agency that is certified by the department to provide prevocational services under:
         1. The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or
         2. The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).
   b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
      (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
      (2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers’ compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent degree. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.
(2) A person providing direct support shall not be an immediate family member of the member.
(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment service training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.
(4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

77.25(10) Supported employment habilitation.

a. The following agencies may provide supported employment services:
(1) An agency that is certified by the department to provide supported employment services under:
   1. The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or
   2. The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).
(2) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.
   (3) An agency that is accredited by the Council on Accreditation.
   (4) An agency that is accredited by the Joint Commission.
   (5) An agency that is accredited by the Council on Quality and Leadership.
   (6) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers’ compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
(1) Individual supported employment: bachelor’s degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.
(2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months’ relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
(3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months’ relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

d. Providers qualified to offer IPS services shall meet the following requirements:
   (1) Providers shall meet the provider qualifications listed in this subrule.
   (2) Providers shall be accredited to provide supported employment and have provided supported employment for a minimum of two years.
   (3) Providers shall demonstrate adequate funding has been secured for the training and technical assistance required for IPS implementation. Adequate funding is defined as at least the amount required for the start-up of one IPS team to complete all phases of IPS implementation. Evidence of such funding shall be made available to the department at the time of enrollment. Evidence may include a written funding agreement or other documentation from the funder.
   (4) Providers shall receive training and technical assistance throughout IPS implementation from an IPS trainer. Evidence of the IPS team’s agreement for such training and technical assistance shall be made available to the department at the time of enrollment.
   (5) Prospective IPS teams shall complete IPS implementation as defined in subrule 77.25(1) and as outlined by the IPS Employment Center at Westat.
   (6) Prospective IPS teams are provisionally approved until the IPS team has obtained at least a “fair” score on a baseline fidelity review completed by IPS reviewers.
   (7) Provisionally approved IPS teams shall complete IPS implementation phases 1 through 4a within 12 months of enrolling.
   (8) Upon completion of IPS implementation phase 4a, provisionally approved IPS teams shall deliver IPS services according to the IPS outcomes model.
   (9) Upon completion of IPS implementation phase 7, IPS teams are qualified to deliver IPS services, subject to the following:
      1. IPS teams must obtain a baseline fidelity review score of “fair” or better within 14 months of completion of IPS implementation phase 1. The fidelity review must be completed by IPS reviewers. The fidelity reviews shall be provided to the department upon receipt by the IPS team.
      2. In the event an IPS team fails to achieve a fidelity score of “fair” or better, the IPS team shall receive technical assistance to address areas recommended for improvement as identified in the fidelity review. If the subsequent fidelity review results in a score of less than “fair” fidelity, the IPS team will be provisionally approved for no more than 12 months or until the fidelity score again reaches “fair” fidelity, whichever date is earliest.
      3. IPS teams who do not achieve a “fair” fidelity score within 12 months from being provisionally approved will no longer be qualified to deliver IPS services until they again reach the minimum “fair” fidelity score.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5890C, IAB 7/28/21, effective 9/1/21; ARC 5889C, IAB 9/8/21, effective 11/1/21]

441—77.26(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.26(1) Licensed marital and family therapists (LMFT). Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.26(2) Temporarily licensed marital and family therapists. Any person who holds a temporary license to practice marital and family therapy pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed marital and family therapist provides treatment under the supervision of a qualified marital and family therapist as determined by the board of behavioral science by rule. Claims for payment for such services must be submitted by the supervising licensed marital and family therapist.
77.26(3) Licensed independent social workers (LISW). Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

77.26(4) Licensed master social workers (LMSW).
   a. A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:
      (1) Holds a master’s or doctoral degree as approved by the board of social work; and
      (2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.
   b. A master social worker in another state is eligible to participate when the person:
      (1) Is duly licensed to practice in that state; and
      (2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

77.26(5) Licensed mental health counselors (LMC). Any person licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code chapter 154D and 645—Chapter 31 is eligible to participate. A mental health counselor in another state is eligible to participate when duly licensed to practice in that state.

77.26(6) Temporarily licensed mental health counselors. Any person temporarily licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code section 154D.7 is eligible to participate when the temporarily licensed mental health counselor provides treatment under the supervision of a qualified mental health counselor as determined by the board of behavioral science by rule. Claims for payment for such services must be submitted by the supervising licensed mental health counselor.

77.26(7) Certified alcohol and drug counselors. Any person certified by the nongovernmental Iowa board of substance abuse certification as an alcohol and drug counselor is eligible to participate.

77.26(8) Licensed behavior analysts. Any person licensed by the board of behavioral science as a behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate. A licensed behavior analyst in another state is eligible to participate when duly licensed to practice in that state.

77.26(9) Licensed assistant behavior analysts. A person licensed by the board of behavioral science as an assistant behavior analyst pursuant to Iowa Code chapter 154D is eligible to participate when the licensed assistant behavior analyst:
   a. Holds current certification as an assistant behavior analyst by a certifying entity; and
   b. Provides treatment under the supervision of a behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

77.26(10) Registered behavior technicians.
   a. A person is eligible to participate as a registered behavior technician when the person holds:
      (1) A current certification from the Behavior Analyst Certification Board as a registered behavior technician; or
      (2) A bachelor’s degree.
   b. A registered behavior technician must provide treatment under the supervision of a behavior analyst or assistant behavior analyst licensed pursuant to Iowa Code chapter 154D. Claims for payment for such services must be submitted by the supervising licensed behavior analyst.

This rule is intended to implement Iowa Code chapter 249A.

[ARC 9649B, IAB 8/10/11, effective 8/1/11; ARC 4165C, IAB 12/5/18, effective 1/9/19; ARC 6388C, IAB 6/29/22, effective 9/1/22]

441—77.27(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

This rule is intended to implement Iowa Code section 249A.4.
441—77.28(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.28(1) Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

77.28(2) Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

77.28(3) Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

77.28(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:
   a. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to 655—Chapter 7;
   b. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
   c. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
   d. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
   e. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

77.28(5) Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

77.28(6) Personnel providing vision services shall be:
   a. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
   b. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
   c. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

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

[ARC 1807C, IAB 1/7/15, effective 3/1/15]

441—77.29(249A) Case management provider organizations. Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

77.29(1) Standards in 441—Chapter 24. Providers shall be accredited as case management providers pursuant to 441—Chapter 24 as a condition of providing case management services to persons with an intellectual disability, developmental disabilities or chronic mental illness.

77.29(2) Standards in 441—Chapter 186. Rescinded IAB 10/12/05, effective 10/1/05.

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

[ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.30(249A) HCBS health and disability waiver service providers. HCBS health and disability waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed
community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.30(18) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

77.30(1) Homemaker providers. Homemaker providers shall be agencies that are:
   a. Certified as a home health agency under Medicare, or
   b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.30(2) Home health aide providers. Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.30(3) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.30(4) Nursing care providers. Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.30(5) Respite care providers.
   a. The following agencies may provide respite services:
      (1) Home health agencies that are certified to participate in the Medicare program.
      (2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
      (3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
      (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
      (5) Camps certified by the American Camping Association.
      (6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
      (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).
      (8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
      (9) Assisted living programs certified by the department of inspections and appeals.
   b. Respite providers shall meet the following conditions:
      (1) Providers shall maintain the following information that shall be updated at least annually:
         1. The consumer’s name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
         2. An emergency medical care release.
         3. Emergency contact telephone numbers such as the number of the consumer’s physician and the parents, guardian, or primary caregiver.
         4. The consumer’s medical issues, including allergies.
         5. The consumer’s daily schedule which includes the consumer’s preferences in activities or foods or any other special concerns.
      (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

   All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer’s name.

   In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.
   (3) Policies shall be developed for:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent’s, guardian’s or primary caregiver’s signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

   c. A facility providing respite under this subrule shall not exceed the facility’s licensed capacity, and services shall be provided in locations consistent with licensure.

   d. Respite provided outside the consumer’s home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.30(6) Counseling providers. Counseling providers shall be:

   a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

   b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

   c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.30(7) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

   a. An individual who contracts with the member to provide attendant care service and who is:

      (1) At least 18 years of age.

      (2) Qualified by training or experience to carry out the member’s plan of care pursuant to the department-approved case plan or individual comprehensive plan.

      (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

      (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

   b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

   c. Home health agencies which are certified to participate in the Medicare program.

   d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

   e. Community action agencies as designated in Iowa Code section 216A.93.

   f. Providers certified under an HCBS waiver for supported community living.

   g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

   h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.30(8) Interim medical monitoring and treatment providers.

   a. The following providers may provide interim medical monitoring and treatment services:

      (1) Home health agencies certified to participate in the Medicare program.

      (2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

   b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:
(1) Be at least 18 years of age.
(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
(3) Not be a usual caregiver of the member.
(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member’s plan of care. The training or experience required must be determined by the member’s usual caregivers and a licensed medical professional on the member’s interdisciplinary team and must be documented in the member’s service plan.
   c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.30(9) Home and vehicle modification providers. The following providers may provide home and vehicle modification:
   a. Area agencies on aging as designated in 17—4.4(231).
   b. Community action agencies as designated in Iowa Code section 216A.93.
   c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
   d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers’ compensation coverage.

77.30(10) Personal emergency response system providers. Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

77.30(11) Home-delivered meals. The following providers may provide home-delivered meals:
   a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.
   b. Community action agencies as designated in Iowa Code section 216A.93.
   c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
   d. Restaurants licensed and inspected under Iowa Code chapter 137F.
   e. Hospitals enrolled as Medicaid providers.
   f. Home health aide providers meeting the standards set forth in subrule 77.33(3).
   g. Medical equipment and supply dealers certified to participate in the Medicaid program.
   h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.30(12) Nutritional counseling. The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:
   a. Hospitals enrolled as Medicaid providers.
   b. Community action agencies as designated in Iowa Code section 216A.93.
   c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
   d. Home health agencies certified by Medicare.
   e. Independent licensed dietitians approved by an area agency on aging.

77.30(13) Financial management service. Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.
   a. The financial institution shall either:
      (1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or
      (2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).
b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.

c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

d. The financial institution shall enroll as a Medicaid provider.

77.30(14) Independent support brokerage. Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

a. The broker must be at least 18 years of age.

b. The broker shall not be the member’s guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.

c. The broker shall not provide any other paid service to the member.

d. The broker shall not work for an individual or entity that is providing services to the member.

e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.

f. The broker must complete independent support brokerage training approved by the department.

77.30(15) Self-directed personal care. Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

a. A business providing self-directed personal care services shall:

   (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

   (2) Have current liability and workers’ compensation coverage.

b. An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver’s license if providing transportation.

c. All personnel providing self-directed personal care services shall:

   (1) Be at least 16 years of age.

   (2) Be able to communicate successfully with the member.

   (3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

   (4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

   (5) Not be the parent or stepparent of a minor child member or the spouse of a member.

   (6) The provider of self-directed personal care services shall:

      (1) Prepare timesheets or invoices approved by the department that identify what services were provided and the time when services were provided.

      (2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(16) Individual-directed goods and services. Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

a. A business providing individual-directed goods and services shall:

   (1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

   (2) Have current liability and workers’ compensation coverage.

b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver’s license if providing transportation.

c. All personnel providing individual-directed goods and services shall:

   (1) Be at least 18 years of age.

   (2) Be able to communicate successfully with the member.
(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

1. Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

2. Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(17) Self-directed community supports and employment. Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

a. A business providing community supports and employment shall:

1. Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

2. Have current liability and workers' compensation coverage.

b. An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver’s license if providing transportation.

c. All personnel providing self-directed community supports and employment shall:

1. Be at least 18 years of age.

2. Be able to communicate successfully with the member.

3. Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

4. Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

5. Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed community supports and employment shall:

1. Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

2. Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(18) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“Minor incident” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
   1. The staff member’s supervisor.
   2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
   3. The consumer’s case manager.
   4. By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:
      1. By direct data entry into the Iowa Medicaid Provider Access System, or
      2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.
   3. The following information shall be reported:
      1. The name of the consumer involved.
      2. The date and time the incident occurred.
      3. A description of the incident.
      4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
      5. The action that the provider staff took to manage the incident.
      6. The resolution of or follow-up to the incident.
      7. The date the report is made and the handwritten or electronic signature of the person making the report.
   4. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.
d. **Tracking and analysis.** The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

### 441—77.31(249A) **Occupational therapists.**

Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

77.31(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.31(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

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

### 441—77.32(249A) **Hospice providers.**

Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

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

### 441—77.33(249A) **HCBS elderly waiver service providers.**

HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

77.33(1) **Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.33(2) **Emergency response system providers.** Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.
77.33(3) Home health aide providers. Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

77.33(4) Homemaker providers. Homemaker providers shall be agencies that are:
   a. Certified as a home health agency under Medicare, or
   b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.33(5) Nursing care. Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.33(6) Respite care providers.
   a. The following agencies may provide respite services:
      (1) Home health agencies that are certified to participate in the Medicare program.
      (2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.
      (3) Camps certified by the American Camping Association.
      (4) Respite providers certified under the home- and community-based services intellectual disability waiver.
      (5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).
      (6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).
      (7) Assisted living programs certified by the department of inspections and appeals.
   b. Respite providers shall meet the following conditions:
      (1) Providers shall maintain the following information that shall be updated at least annually:
         1. The consumer’s name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
         2. An emergency medical care release.
         3. Emergency contact telephone numbers such as the number of the consumer’s physician and the spouse, guardian, or primary caregiver.
         4. The consumer’s medical issues, including allergies.
         5. The consumer’s daily schedule which includes the consumer’s preferences in activities or foods or any other special concerns.
      (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.
      All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer’s name.
      In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.
      (3) Policies shall be developed for:
         1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse’s, guardian’s or primary caregiver’s signature is required to verify receipt of notification.
         2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
         3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.
         4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
      c. A facility providing respite under this subrule shall not exceed the facility’s licensed capacity, and services shall be provided in locations consistent with licensure.
      d. Respite provided outside the consumer’s home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver.
and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.33(7) Chore providers. The following providers may provide chore services:
   a. Home health agencies certified under Medicare.
   b. Community action agencies as designated in Iowa Code section 216A.93.
   c. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
   d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
   e. Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.
      f. Community businesses that are engaged in the provision of chore services and that:
         (1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and
         (2) Submit verification of current liability and workers’ compensation coverage.

77.33(8) Home-delivered meals. The following providers may provide home-delivered meals:
   a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.
   b. Community action agencies as designated in Iowa Code section 216A.93.
   c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
   d. Restaurants licensed and inspected under Iowa Code chapter 137F.
   e. Hospitals enrolled as Medicaid providers.
   f. Home health aide providers meeting the standards set forth in subrule 77.33(3).
   g. Medical equipment and supply dealers certified to participate in the Medicaid program.
   h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.33(9) Home and vehicle modification providers. The following providers may provide home and vehicle modification:
   a. Area agencies on aging as designated in 17—4.4(231).
   b. Community action agencies as designated in Iowa Code section 216A.93.
   c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.
   d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers’ compensation coverage.

77.33(10) Mental health outreach providers. Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

77.33(11) Transportation providers. The following providers may provide transportation:
   a. Area agencies on aging as designated in 17—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.
   b. Community action agencies as designated in Iowa Code section 216A.93.
   c. Regional transit agencies as recognized by the Iowa department of transportation.
   e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
   f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.33(12) Nutritional counseling. The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:
a. Hospitals enrolled as Medicaid providers.
b. Community action agencies as designated in Iowa Code section 216A.93.
c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
d. Home health agencies certified by Medicare.
e. Independent licensed dietitians.

77.33(13) **Assistive device providers.** The following providers may provide assistive devices:
- a. Medicaid-enrolled medical equipment and supply dealers.
- b. Area agencies on aging as designated according to department on aging rules 17—4.4(231) and 17—4.9(231).
- c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.
- d. Community businesses that are engaged in the provision of assistive devices and that:
  1. Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and
  2. Submit verification of current liability and workers’ compensation coverage.

77.33(14) **Senior companions.** Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

77.33(15) **Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:
- a. An individual who contracts with the member to provide attendant care service and who is:
  1. At least 18 years of age.
  2. Qualified by training or experience to carry out the member’s plan of care pursuant to the department-approved case plan or individual comprehensive plan.
  3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
  4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
- c. Home health agencies which are certified to participate in the Medicare program.
- d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e. Community action agencies as designated in Iowa Code section 216A.93.
- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.33(16) **Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.33(17) **Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.33(18) **Self-directed personal care.** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.33(19) **Individual-directed goods and services.** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.33(20) **Self-directed community supports and employment.** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).
77.33(21) **Case management providers.** A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

a. The case management provider shall be an agency or individual that:

   1. Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or
   2. Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or
   3. Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or
   4. Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or
   5. Is approved by the department on aging as meeting the standards for case management services in 17—Chapter 21; or
   6. Is authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services and that:

      1. Meets the qualifications for case managers in 641—subrule 80.6(1); and
      2. Provides a current IDPH local public health services contract number.

b. A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

   1. Specific procedures to identify conflicts of interest.
   2. Procedures to eliminate any conflict of interest that is identified.
   3. Procedures for handling complaints of conflict of interest, including written documentation.

c. If the case management provider organization subcontracts case management services to another entity:

   1. That entity must also meet the provider qualifications in this subrule; and
   2. The contractor is responsible for verification of compliance.

77.33(22) **Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. **EXCEPTION:** The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

a. **Definitions.**

   "Major incident" means an occurrence involving a consumer during service provision that:

   1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
   2. Results in the death of any person;
   3. Requires emergency mental health treatment for the consumer;
   4. Requires the intervention of law enforcement;
   5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
   6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
   7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

   "Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:
1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
   1. The staff member’s supervisor.
   2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
   3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:
   1. By direct data entry into the Iowa Medicaid Provider Access System, or
   2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:
   1. The name of the consumer involved.
   2. The date and time the incident occurred.
   3. A description of the incident.
   4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
   5. The action that the provider staff took to manage the incident.
   6. The resolution of or follow-up to the incident.
   7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.33(23) Assisted living on-call service.** Assisted living on-call service providers shall be assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]
**441—77.34(249A) HCBS AIDS/HIV waiver service providers.** HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choice option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choice option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards set forth below for the service to be provided:

77.34(1) **Counseling providers.** Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.34(2) **Home health aide providers.** Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.34(3) **Homemaker providers.** Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.34(4) **Nursing care providers.** Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

77.34(5) **Respite care providers.**

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.

(3) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).

(8) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer’s name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer’s physician and the parents, guardian, or primary caregiver.

4. The consumer’s medical issues, including allergies.
5. The consumer’s daily schedule which includes the consumer’s preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer’s name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent’s, guardian’s or primary caregiver’s signature is required to verify receipt of notification.

2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

   a. A facility providing respite under this subrule shall not exceed the facility’s licensed capacity, and services shall be provided in locations consistent with licensure.

   d. Respite provided outside the consumer’s home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.34(6) Home-delivered meals. The following providers may provide home-delivered meals:

   a. Home health aide providers meeting the standards set forth in subrule 77.34(2).

   b. Home care providers meeting the standards set forth in subrule 77.34(3).

   c. Hospitals enrolled as Medicaid providers.

   d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

   e. Restaurants licensed and inspected under Iowa Code chapter 137F.

   f. Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

   g. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

   h. Medical equipment and supply dealers certified to participate in the Medicaid program.

77.34(7) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.34(8) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

   a. An individual who contracts with the member to provide attendant care service and who is:

      1. At least 18 years of age.

      2. Qualified by training or experience to carry out the member’s plan of care pursuant to the department-approved case plan or individual comprehensive plan.

      3. Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.34(9) Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.34(10) Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.34(11) Self-directed personal care.** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.34(12) Individual-directed goods and services.** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.34(13) Self-directed community supports and employment.** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

**77.34(14) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

a. **Definitions.**

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“Minor incident” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

1. The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
   1. The staff member’s supervisor.
   2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
   3. The consumer’s case manager.

2. By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:
   1. By direct data entry into the Iowa Medicaid Provider Access System, or
   2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

3. The following information shall be reported:
   1. The name of the consumer involved.
   2. The date and time the incident occurred.
   3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
   1. The action that the provider staff took to manage the incident.
   2. The resolution of or follow-up to the incident.
   3. The date the report is made and the handwritten or electronic signature of the person making the report.

4. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—77.35(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

This rule is intended to implement Iowa Code section 249A.4.
441—77.36(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

77.36(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

77.36(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.36(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

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

441—77.37(249A) Home- and community-based services intellectual disability waiver service providers. Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)“a”(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules 77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS intellectual disability waiver service providers.

77.37(1) Organizational standards (Outcome 1). Organizational outcome-based standards for home- and community-based services intellectual disability providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumer’s needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve.

These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.
(2) Confidentiality.
(3) Provision of consumer medication.
(4) Identification and reporting of child and dependent adult abuse.
(5) Individual consumer support needs.
f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

1. Measures and assesses organizational activities and services annually.
2. Gathers information from consumers, family members, and staff.
3. Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).
4. Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.
5. Identifies areas in need of improvement.
6. Develops a plan to address the areas in need of improvement.
7. Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider’s implementation of the 20 outcomes, or staff or contractual person’s action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

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

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.37(2) Rights and dignity. Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

...
affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.37(5) Storage and provision of medication. If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider’s prescribed medication regime at least annually in accordance with current medical practice.

77.37(6) Research. If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

77.37(7) Abuse reporting requirements. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

77.37(8) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS intellectual disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

“Major incident” means an occurrence involving a consumer during service provision that:
1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“Minor incident” means an occurrence involving a consumer during service provision that is not a major incident and that:
1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:
   1. The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
      1. The staff consumer’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.

3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

\( \text{d. Tracking and analysis.} \) The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

\( \text{77.37(9) Intake, admission, service coordination, discharge, and referral.} \)

\( \text{a.} \) The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. 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.

\( \text{b.} \) The provider shall ensure the rights of persons applying for services.

\( \text{77.37(10) Certification process.} \) Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services’ bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

\( \text{a.} \) Rescinded IAB 9/1/04, effective 11/1/04.

\( \text{b.} \) Rescinded IAB 9/1/04, effective 11/1/04.

\( \text{c.} \) Rescinded IAB 9/1/04, effective 11/1/04.

\( \text{d.} \) The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.
77.37(11) Initial certification. The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

1. The application for status as an approved provider according to requirements of rules.

2. A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

3. The prospective provider’s coordination of service design, development, and application with the applicable region and other interested parties.

4. The prospective provider’s written agreement to work cooperatively with the state, counties and regions to be served by the provider.

c. Providers applying for initial certification shall be offered technical assistance.

77.37(12) Period of certification. Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer’s life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

1. Three-year certification with excellence. An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored
through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) Three-year certification with follow-up monitoring. An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) One-year certification. An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. “Immediate jeopardy” refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider’s services that was the subject of the notification shall not be certified. The department shall be notified immediately to discontinue funding for that provider’s service. If a member is in immediate jeopardy, the case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider’s services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider’s inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department’s approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider’s approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)“e.”

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13)“f.”

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)“h.”
(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from a home- and community-based services intellectual disability waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider’s corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.37(13) Review of providers. Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department’s written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team’s visit. The corrective actions may include: specific problem areas cited, corrective actions to be implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13)”e” and 77.37(13)”f”

h. The department may conduct a site visit to verify all or part of the information submitted.

77.37(14) Supported community living providers.

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

  (1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

  1. Implementation of necessary staff training and consumer input.

  2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.
(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.37(15) Respite care providers.

a. The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for persons with an intellectual disability, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with an intellectual disability licensed by the department of inspections and appeals.

(4) Home health agencies that are certified to participate in the Medicare program.

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

(7) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(8) Agencies certified by the department to provide respite services in the consumer’s home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer’s name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer’s physician and the parents, guardian, or primary caregiver.
4. The consumer’s medical issues, including allergies.
5. The consumer’s daily schedule which includes the consumer’s preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer’s name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent’s, guardian’s or primary caregiver’s signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
   a. A facility providing respite under this subrule shall not exceed the facility’s licensed capacity, and services shall be provided in locations consistent with licensure.
   b. Respite provided outside the consumer’s home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.37(16) Supported employment providers.
   a. The following agencies may provide supported employment services:
      (1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.
      (2) An agency that is accredited by the Council on Accreditation for similar services.
      (3) An agency that is accredited by the Joint Commission for similar services.
      (4) An agency that is accredited by the Council on Quality and Leadership for similar services.
      (5) An agency that is accredited by the International Center for Clubhouse Development.
   b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
      (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
      (2) Member vacation, sick leave and holiday compensation.
      (3) Procedures for payment schedules and pay scale.
      (4) Procedures for provision of workers’ compensation insurance.
      (5) Procedures for the determination and review of commensurate wages.
   c. Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.
   d. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
      (1) Individual supported employment: bachelor’s degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.
      (2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months’ relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
      (3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months’ relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
      (4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

77.37(17) Home and vehicle modification providers. The following providers may provide home and vehicle modification:
a. Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers’ compensation insurance.

77.37(18) Personal emergency response system providers. Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

77.37(19) Nursing providers. Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.37(20) Home health aide providers. Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

77.37(21) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:
   (1) At least 18 years of age.
   (2) Qualified by training or experience to carry out the member’s plan of care pursuant to the department-approved case plan or individual comprehensive plan.
   (3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.
   (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.37(22) Interim medical monitoring and treatment providers.

a. The following providers may provide interim medical monitoring and treatment services:
   (1) Home health agencies certified to participate in the Medicare program.
   (2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:
   (1) Be at least 18 years of age.
   (2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.
   (3) Not be a usual caregiver of the member.
   (4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member’s plan of care. The training or experience required must be determined by the member’s usual caregivers and a licensed medical professional on the member’s interdisciplinary team and must be documented in the member’s service plan.
c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.37(23) Residential-based supported community living service providers.

a. The department shall contract only with public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

1. Agencies licensed as group living foster care facilities under 441—Chapter 114.

2. Agencies licensed as residential facilities for children with an intellectual disability or brain injury under 441—Chapter 116.

3. Other agencies providing residential-based supported community living services that meet the following conditions:

   1. The agency must provide orientation training on the agency’s purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children’s intellectual disabilities and developmental disabilities services and children’s mental health issues. Identification and reporting of child abuse shall be covered in training at least every three years, in accordance with Iowa Code section 232.69.

   2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:
      • Children, their families, and their legal representatives decide what personal information is shared and with whom.
      • Children are a part of family and community life and perform varied social roles.
      • Children have family connections, a social network, and varied relationships.
      • Children develop and accomplish personal goals.
      • Children are valued.
      • Children live in positive environments.
      • Children exercise their rights and responsibilities.
      • Children make informed choices about how they spend their free time.
      • Children choose their daily routine.

   3. The agency must use methods of self-evaluation by which:
      • Past performance is reviewed.
      • Current functioning is evaluated.
      • Plans are made for the future based on the review and evaluation.

   4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

   5. Children, their parents, and their legal representatives must have the right to appeal the service provider’s application of policies or procedures or any staff person’s action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

   1. Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

   2. Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

   3. The provider’s written agreement to work cooperatively with the department.
d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:

1. The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

2. Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

3. The service plan shall identify the following:
   1. Strengths and needs of the child.
   2. Goals to be achieved to meet the needs of the child.
   3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
   4. Specific service activities to be provided to achieve the objectives.
   5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
   6. Date of service initiation and date of individual service plan development.
   7. Service goals describing how the child will be reunited with the child’s family and community.

4. Individuals qualified to provide all services identified in the service plan shall review the services identified in the plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on the Supports Intensity Scale® (SIS) assessment.

5. The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

6. The individual service plan shall be revised when any of the following occur:
   1. Service goals or objectives have been achieved.
   2. Progress toward goals and objectives is not being made.
   3. Changes have occurred in the identified service needs of the child, as listed on the Supports Intensity Scale® (SIS) assessment.

7. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

7. The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

8. Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

1. Rescinded IAB 8/7/02, effective 10/1/02.

2. There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.
(3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.
2. What physical change will need to take place in the living units.
3. How children and their families will be involved in the transitioning process.
4. How this transition will affect children’s social and educational environment.

f. Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. “Immediate jeopardy” refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department shall immediately discontinue funding for that provider’s service. If this action is appealed and the member or legal guardian wants to maintain the provider’s services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk. The case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department’s approval decision exists which is beyond the control of the provider or department.
• A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider’s approval at any time for any of the following reasons:

• The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)‘e’ and numbered paragraph 77.37(23)‘f’(3)‘4.’
• The provider has failed to provide information requested pursuant to paragraph 77.37(13)‘f’ and numbered paragraph 77.37(23)‘f’(3)‘4.’
• The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)‘h’ and subparagraph 77.37(23)‘f’(3).
• There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

4 Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

77.37(24) Transportation service providers. The following providers may provide transportation:

a. Accredited providers of home- and community-based services.

b. Regional transit agencies as recognized by the Iowa department of transportation.

c. Transportation providers that contract with county governments.

d. Community action agencies as designated in Iowa Code section 216A.93.

e. Nursing facilities licensed under Iowa Code chapter 135C.

f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.

g. Transportation providers contracting with the nonemergency medical transportation contractor.

77.37(25) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.37(26) Prevocational service providers.

a. Providers of prevocational services must be accredited by one of the following:

(1) The Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(2) The Council on Quality and Leadership accreditation in supports for people with disabilities.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers’ compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.

(4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

77.37(27) Day habilitation providers. Day habilitation services may be provided by agencies meeting the qualifications in subrule 77.25(7).

77.37(28) Financial management service. Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.37(29) Independent support brokerage. Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.37(30) Self-directed personal care. Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.37(31) Individual-directed goods and services. Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.37(32) Self-directed community supports and employment. Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5361C, IAB 12/30/20, effective 3/1/21]

441—77.38(249A) Assertive community treatment. Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

77.38(1) Minimum composition. At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

77.38(2) Psychiatrists. A psychiatrist on the team shall be a physician (MD or DO) who:

a. Is licensed under 653—Chapter 9,

b. Is certified as a psychiatrist by the American Board of Medical Specialties’ Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, and

c. Has experience treating serious and persistent mental illness.

77.38(3) Registered nurses. A nurse on the team shall:

a. Be licensed as a registered nurse under 655—Chapter 3, and

b. Have experience treating persons with serious and persistent mental illness.

77.38(4) Mental health service providers. A mental health service provider on the team shall be:

a. A mental health counselor or marital and family therapist who:

(1) Is licensed under 645—Chapter 31, and

(2) Has experience treating persons with serious and persistent mental illness; or

b. A social worker who:

(1) Is licensed as a master or independent social worker under 645—Chapter 280, and

(2) Has experience treating persons with serious and persistent mental illness.

77.38(5) Psychologists. A psychologist on the team shall:
a. Be licensed under 645—Chapter 240, and
b. Have experience treating persons with serious and persistent mental illness.

77.38(6) Substance abuse treatment professionals. A substance abuse treatment professional on the team shall:
  a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8)“i,” and
  b. Have at least three years of experience treating substance abuse.

77.38(7) Peer specialists. A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

77.38(8) Community support specialists. A community support specialist on the team shall be a person who:
  a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and
  b. Has experience supporting persons with serious and persistent mental illness.

77.38(9) Case managers. A case manager on the team shall be a person who:
  a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),
  b. Has experience managing care for persons with serious and persistent mental illness, and
  c. Meets the qualifications of “qualified case managers and supervisors” in rule 441—24.1(225C).

77.38(10) Advanced registered nurse practitioners. An advanced registered nurse practitioner on the team shall:
  a. Be licensed under 655—Chapter 7,
  b. Have a mental health certification, and
  c. Have experience treating serious and persistent mental illness.

77.38(11) Physician assistants. A physician assistant on the team shall:
  a. Be licensed under 645—Chapter 326,
  b. Have experience treating persons with serious and persistent mental illness, and
  c. Practice under the supervision of a psychiatrist.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—77.39(249A) HCBS brain injury waiver service providers. Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department’s brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject
to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS brain injury waiver service providers.

77.39(1) Organizational standards (Outcome 1). Organizational outcome-based standards for HCBS BI providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumers’ needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve.

These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

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

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider’s implementation of the 20 outcomes, or staff or contractual person’s action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

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

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.39(2) Rights and dignity. Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.
f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers’ money is addressed on an individualized basis.

p. (Outcome 17) Consumers maintain good health.

q. (Outcome 18) The consumer’s living environment is reasonably safe in the consumer’s home and community.

r. (Outcome 19) The consumer’s desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.39(3) The right to appeal. Consumers and their legal representatives have the right to appeal the provider’s application of policies or procedures, or any staff or contractual person’s action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.39(4) Storage and provision of medication. If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

77.39(5) Research. If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers’ rights are protected.

77.39(6) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. Exception: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or

7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“Minor incident” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
   1. The staff member’s supervisor.
   2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
   3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:
   1. By direct data entry into the Iowa Medicaid Provider Access System, or
   2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:
   1. The name of the consumer involved.
   2. The date and time the incident occurred.
   3. A description of the incident.
   4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
   5. The action that the provider staff took to manage the incident.
   6. The resolution of or follow-up to the incident.
   7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.39(7) Intake, admission, service coordination, discharge, and referral.

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.39(8) Certification process. Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services’ bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.
b. Rescinded IAB 9/1/04, effective 11/1/04.
c. Rescinded IAB 9/1/04, effective 11/1/04.
d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:
   (1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.
   (2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.39(9) Initial certification. The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

   a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.
   b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:
      (1) The application for status as an approved provider according to requirements of rules.
      (2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.
   c. Providers applying for initial certification shall be offered technical assistance.

77.39(10) Period of certification. Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

   a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.
   b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer’s life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

   Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

   An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

   Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.
   c. The department may issue four categories of recertification:
(1) **Three-year certification with excellence.** An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) **Three-year certification with follow-up monitoring.** An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) **One-year certification.** An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) **Probational certification.** A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.


d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. “Immediate jeopardy” refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider’s services that was the subject of the notification shall not be certified. The department shall immediately discontinue funding for that provider’s service.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider’s services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider’s inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department’s approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider’s approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11)“d.”

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11)“e.”
(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11)“f.”

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider’s corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.39(11) Departmental reviews. Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department’s determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11)“c” and “d.”

f. The department may conduct a site visit to verify all or part of the information submitted.

77.39(12) Case management service providers. Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.39(13) Supported community living providers.

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:
(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:
1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.39(14) Respite service providers. Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

a. The following agencies may provide respite services:
1. Respite providers certified under the HCBS intellectual disability waiver.
2. Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).
3. Group living foster care facilities for children licensed by the department according to Ch 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
4. Camps certified by the American Camping Association.
5. Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
6. Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
7. Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
8. Home health agencies that are certified to participate in the Medicare program.
9. Agencies certified by the department to provide respite services in the consumer’s home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).
10. Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:
1. Providers shall maintain the following information that shall be updated at least annually:
   1. The consumer’s name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
   2. An emergency medical care release.
   3. Emergency contact telephone numbers such as the number of the consumer’s physician and the parents, guardian, or primary caregiver.
   4. The consumer’s medical issues, including allergies.
   5. The consumer’s daily schedule which includes the consumer’s preferences in activities or foods or any other special concerns.
2. Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

   All medications shall be stored in their original containers, with the accompanying physician’s or pharmacist’s directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer’s name.

   In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

3. Policies shall be developed for:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent’s, guardian’s or primary caregiver’s signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
   c. A facility providing respite under this subrule shall not exceed the facility’s licensed capacity, and services shall be provided in locations consistent with licensure.
   d. Respite provided outside the consumer’s home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.39(15) Supported employment providers.
   a. The following agencies may provide supported employment services:
      (1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider or a provider of a similar service.
      (2) An agency that is accredited by the Council on Accreditation for similar services.
      (3) An agency that is accredited by the Joint Commission for similar services.
      (4) An agency that is accredited by the Council on Quality and Leadership for similar services.
      (5) An agency that is accredited by the International Center for Clubhouse Development.
   b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
      (1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
      (2) Member vacation, sick leave and holiday compensation.
      (3) Procedures for payment schedules and pay scale.
      (4) Procedures for provision of workers’ compensation insurance.
      (5) Procedures for the determination and review of commensurate wages.
   c. Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.
   d. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
      (1) Individual supported employment: bachelor’s degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.
      (2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months’ relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
      (3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months’ relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.
      (4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

77.39(16) Home and vehicle modification providers. The following providers may provide home and vehicle modification:
   a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.
b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers’ compensation insurance.

77.39(17) Personal emergency response system providers. Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

77.39(18) Transportation service providers. This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.39(19) Specialized medical equipment providers. The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

77.39(20) Adult day care providers. Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.39(21) Family counseling and training providers. Family counseling and training providers shall be one of the following:

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

e. Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

f. Agencies which are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.

77.39(22) Prevocational services providers.

a. Providers of prevocational services must be accredited by one of the following:
(1) The Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.
(2) The Council on Quality and Leadership accreditation in supports for people with disabilities.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.
(2) Member vacation, sick leave and holiday compensation.
(3) Procedures for payment schedules and pay scale.
(4) Procedures for provision of workers’ compensation insurance.
(5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:
(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.
(2) A person providing direct support shall not be an immediate family member of the member.
(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.
(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

77.39(23) Behavioral programming providers. Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers’ intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:
(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.
(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.
(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.
(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.
(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).
(6) Agencies which are accredited by a department-approved, nationally recognized accreditation organization as specialty brain injury rehabilitation service providers.
(7) Individuals who meet the definition of “qualified brain injury professional” as set forth in rule 441—83.81(249A).

77.39(24) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:
(1) At least 18 years of age.
 Qualified by training or experience to carry out the member’s plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.39(25) Interim medical monitoring and treatment providers.

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member’s plan of care. The training or experience required must be determined by the member’s usual caregivers and a licensed medical professional on the member’s interdisciplinary team and must be documented in the member’s service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.39(26) Financial management service. Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.39(27) Independent support brokerage. Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.39(28) Self-directed personal care. Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.39(29) Individual-directed goods and services. Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.39(30) Self-directed community supports and employment. Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

This rule is intended to implement Iowa Code section 249A.4. [ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0575C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 1638C, IAB 10/1/14, effective 11/5/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4792C, IAB 12/4/19, effective 1/8/20]
441—77.40(249A) Lead inspection agencies. The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services. This rule is intended to implement Iowa Code section 249A.4.

441—77.41(249A) HCBS physical disability waiver service providers. Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers. The integrated, community-based settings standards in subrule 77.25(5) apply to all HCBS physical disability waiver service providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

77.41(1) Enrollment process. Reviews of compliance with standards for initial enrollment shall be conducted by the department’s quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.41(2) Consumer-directed attendant care providers. The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide consumer-directed attendant care and who is:

1. At least 18 years of age.
2. Qualified by training or experience to carry out the member’s plan of care pursuant to the department-approved case plan or individual comprehensive plan.
3. Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
4. Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies that are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.103.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.
77.41(3) Home and vehicle modification providers. The following providers may provide home and vehicle modifications:
   a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home-and-community-based services intellectual disability or brain injury waiver.
   b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers’ compensation insurance.

77.41(4) Personal emergency response system providers. Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

77.41(5) Specialized medical equipment providers. The following providers may provide specialized medical equipment:
   a. Medical equipment and supply dealers participating as providers in the Medicaid program.
   b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

77.41(6) Transportation service providers. The following providers may provide transportation:
   a. Area agencies on aging as designated in 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.
   b. Community action agencies as designated in Iowa Code section 216A.93.
   c. Regional transit agencies as recognized by the Iowa department of transportation.
   d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
   e. Transportation providers contracting with the nonemergency medical transportation contractor.

77.41(7) Financial management service. Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.41(8) Independent support brokerage. Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.41(9) Self-directed personal care. Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.41(10) Individual-directed goods and services. Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.41(11) Self-directed community supports and employment. Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

77.41(12) Incident management and reporting. As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.
   a. Definitions.
      “Major incident” means an occurrence involving a consumer during service provision that:
      1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
      2. Results in the death of any person;
      3. Requires emergency mental health treatment for the consumer;
      4. Requires the intervention of law enforcement;
      5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“Minor incident” means an occurrence involving a consumer during service provision that is not a major incident and that:
1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:
   (1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
      1. The staff member’s supervisor.
      2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
      3. The consumer’s case manager.
   (2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:
      1. By direct data entry into the Iowa Medicaid Provider Access System, or
      2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.
   (3) The following information shall be reported:
      1. The name of the consumer involved.
      2. The date and time the incident occurred.
      3. A description of the incident.
      4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
      5. The action that the provider staff took to manage the incident.
      6. The resolution of or follow-up to the incident.
      7. The date the report is made and the handwritten or electronic signature of the person making the report.
   (4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.
d. **Tracking and analysis.** The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

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**441—77.42(249A) Public health agencies.** Public health agencies are eligible to participate in the medical assistance program when they serve as a public health entity within the local board of health jurisdiction pursuant to 641—subrule 77.3(3).

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

[ARC 0358C; IAB 10/3/12, effective 11/7/12]

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**441—77.43(249A) Infant and toddler program providers.** An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and

2. Meets the following additional requirements.

**77.43(1) Licensure.** Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

   1. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
   2. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
   3. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
   4. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
   5. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

   1. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
   2. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
   3. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.
g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:
   (1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);
   (2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
   (3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);
   (4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);
   (5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);
   (6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);
   (7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);
   (8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);
   (9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or
   (10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.43(2) Documentation requirements. As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child’s record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).

d. Documentation of progress toward achieving the child’s or family’s action steps and outcomes as identified in the individual family service plan (IFSP).

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

441—77.44(249A) Local education agency services providers. School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

77.44(1) Licensure. Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.
d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:
   (1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
   (2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
   (3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
   (4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
   (5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:
   (1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
   (2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
   (3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:
   (1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);
   (2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
   (3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);
   (4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);
   (5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);
   (6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);
   (7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);
   (8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);
   (9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or
   (10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.44(2) Documentation requirements. As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child’s record. Documentation of all services performed is required and must include:

a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.
c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

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

441—77.45(249A) Indian health facilities. A health care facility operated by the U.S. Indian Health Service or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) by an “Indian tribe,” “tribal organization,” or “Urban Indian organization,” as those terms are defined in 25 U.S.C. 1603, is eligible to participate in the medical assistance program if the following conditions are met:

77.45(1) Licensure. Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.45(2) Documentation. Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

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

[ARC 2930C, IAB 2/1/17, effective 4/1/17]

441—77.46(249A) HCBS children’s mental health waiver service providers. HCBS children’s mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and the integrated, community-based settings standards in subrule 77.25(5) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children’s mental health waiver.

77.46(1) General provider standards. All providers of HCBS children’s mental health waiver services shall meet the following standards:

a. Fiscal capacity. Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. Direct care staff.

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

c. Outcome-based standards and quality assurance.

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.
2. Consumers are a part of community life.
3. Consumers develop meaningful goals.
4. Consumers maintain physical and mental health.
5. Consumers are safe.
6. Consumers and their families have an impact on the services received.

(2) The department’s quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer’s parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.
(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department’s quality assurance staff.

d. Incident management and reporting. As a condition of participation in the medical assistance program, HCBS children’s mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. EXCEPTION: The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:
1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:
1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(2) Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:
1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(5) Information to be reported. The following information shall be reported about a major incident:
1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.46(2) Environmental modifications, adaptive devices, and therapeutic resources providers. The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children’s mental health waiver:

a. A community business that:
   (1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and
   (2) Submits verification of current liability and workers’ compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS home- and community-based services intellectual disability or brain injury waiver as a supported community living provider.

e. A provider enrolled under the HCBS children’s mental health waiver as a family and community support services provider.

77.46(3) Family and community support services providers.

a. Qualified providers. The following agencies may provide family and community support services under the children’s mental health waiver:
   (1) Behavioral health intervention providers qualified under 441—77.12(249A).
   (2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. Staff training. The agency shall meet the following training requirements as a condition of providing family and community support services under the children’s mental health waiver:
   (1) Within one month of employment, staff members must receive the following training:
      1. Orientation regarding the agency’s mission, policies, and procedures; and
      2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1)“c” for the children’s mental health waiver.
   (2) Within four months of employment, staff members must receive training regarding the following:
      1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
      2. Confidentiality;
      3. Provision of medication according to agency policy and procedure;
      4. Identification and reporting of child abuse;
      5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children’s mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children’s mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children’s mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer’s interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer’s crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer’s parents or legal guardian, regarding the consumer’s individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer’s mental health or change the consumer’s crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children’s mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.46(4) In-home family therapy providers.

a. Qualified providers. The following agencies may provide in-home family therapy under the children’s mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

b. Staff training. The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children’s mental health waiver:

(1) Within one month of employment, staff members must receive the following training:
   1. Orientation regarding the agency’s mission, policies, and procedures; and
   2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1) “c.” for the children’s mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:
   1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;
   2. Confidentiality;
   3. Provision of medication according to agency policy and procedure;
   4. Identification and reporting of child abuse;
   5. Incident reporting;
   6. Documentation of service provision;
   7. Appropriate behavioral interventions; and
   8. Professional ethics.
(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children’s mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children’s mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children’s mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer’s interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer’s crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer’s parents or legal guardian, regarding the consumer’s individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer’s mental health or change the consumer’s crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children’s mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.46(5) Respite care providers.

a. Qualified providers. The following agencies may provide respite services under the children’s mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Camps certified in good standing by the American Camping Association.

(4) Home health agencies that are certified in good standing to participate in the Medicare program.

(5) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(6) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

(7) Assisted living programs certified in good standing by the department of inspections and appeals.

(8) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(9) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

b. Staff training. The agency shall meet the following training requirements as a condition of providing respite care under the children’s mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency’s mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children’s mental health waiver in 77.46(1)”c."

(2) Within four months of employment, staff members must receive training regarding the following:
1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;
2. Confidentiality;
3. Provision of medication according to agency policy and procedure;
4. Identification and reporting of child abuse;
5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children’s mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children’s mental health issues.

c. Consumer-specific information. The following information must be written, current, and accessible to the respite provider during service provision:

(1) The consumer’s legal and preferred name, birth date, and age, and the address and telephone number of the consumer’s usual residence.

(2) The consumer’s typical schedule.

(3) The consumer’s preferences in activities and foods or any other special concerns.

(4) The consumer’s crisis intervention plan.

d. Written notification of injury. The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

e. Medication dispensing. Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

f. Support of crisis intervention plan. As a condition of providing services under the children’s mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer’s interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer’s crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer’s parents or legal guardian, regarding the consumer’s individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer’s mental health or change the consumer’s crisis intervention plan.

g. Service documentation. Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

h. Capacity: A facility providing respite care under this subrule shall not exceed the facility’s licensed capacity, and services shall be provided in a location and for a duration consistent with the facility’s licensure.

i. Service provided outside home or facility. For respite care to be provided in a location other than the consumer’s home or the provider’s facility:

(1) The care must be approved by the parent, guardian or usual caregiver;
(2) The care must be approved by the interdisciplinary team in the consumer’s service plan;
(3) The care must be consistent with the way the location is used by the general public; and
(4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—77.47(249A) Health home services providers. Subject to the requirements of this rule, a provider may participate in the medical assistance program as a provider of health home services.

77.47(1) Definitions.

“Chronic condition” means, for purposes of this rule, one of the conditions outlined in 441—subparagraph 78.53(3)”a”(1).

“Chronic condition health home” means a provider enrolled to deliver personalized, coordinated care for members with one chronic condition and at risk of developing another.

“Functional impairment” means the loss of functional capacity that (1) is episodic, recurrent, or continuous; (2) substantially interferes with or limits the achievement of or maintenance of one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills; and (3) substantially interferes with or limits the individual’s functional capacity with family, employment, school, or community. “Functional impairment” does not include difficulties resulting from temporary and expected responses to stressful events in a person’s environment. The level of functional impairment must be identified by the assessment completed by a mental health professional as defined in rule 441—24.1(225C).

“Health home” means a chronic condition health home or an integrated health home.

“Integrated health home” means a provider enrolled to integrate medical, social, and behavioral health care needs for adults with a serious mental illness and children with a serious emotional disturbance.

“Lead entity” means a managed care organization that supports and oversees the chronic condition health home and the integrated health home network.

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

“Serious emotional disturbance” means the same as defined in rule 441—83.121(249A).

“Serious mental illness” means, for an adult, a persistent or chronic mental health, behavioral, or emotional disorder that (1) is specified within the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or its most recent International Classification of Diseases, and (2) causes serious functional impairment and substantially interferes with or limits one or more major life activities, including functioning in the family, school, employment or community. “Serious mental illness” may co-occur with substance use disorder, developmental disabilities, neurodevelopmental disabilities or intellectual disabilities, but those diagnoses may not be the clinical focus for health home services.

77.47(2) Chronic condition health home provider qualifications.

a. A chronic condition health home must be one of the following:
   (1) Physician(s).
   (2) Clinical practice or clinical group practice.
   (3) Rural health clinic.
   (4) Community health center.
   (5) Community mental health center accredited under 441—Chapter 24.
   (6) Federally qualified health clinic.

b. A chronic condition health home may include multiple sites when those sites are identified as a single organization or medical group that shares policies, procedures, and electronic systems across all of the single organization’s or medical group’s practice sites.
c. A chronic condition health home must achieve accreditation, recognition, or certification as a patient-centered medical home (PCMH) through a national accreditation or certification entity recognized by the department within the first year of operation and maintain the accreditation, recognition, or certification for the duration of enrollment as a health home. A chronic condition health home that fails to achieve accreditation, recognition, or certification within the first year of enrollment will have the chronic condition health home enrollment terminated unless granted an extension by the department.

d. A chronic condition health home must complete a self-assessment when enrolling as a new health home and annually thereafter.

e. A chronic condition health home must meet the requirements, qualifications, and standards outlined in the chronic condition health home state plan amendment.

f. A chronic condition health home must participate in monthly, quarterly, and annual outcomes data collection and reporting.

g. At a minimum, a chronic condition health home must fill the following roles:
   (1) Designated practitioner. The chronic condition health home must have at least one physician with an active Iowa license and credentialed with at least one managed care organization. If a chronic condition health home has multiple sites, a specific site may have a nurse practitioner or physician assistant, so long as the chronic condition health home has at least one physician.
   (2) Nurse care manager. The chronic condition health home must have at least one nurse care manager who is a registered nurse or has a bachelor of science in nursing with an active Iowa nursing license in accordance with rule 655—3.3(17A,147,152,272C).
   (3) Health coach. The chronic condition health home must have at least one trained health coach.

77.47(3) Integrated health home provider qualifications.

a. An integrated health home must be one of the following:
   (1) Community mental health center accredited under 441—Chapter 24.
   (2) Licensed mental health service provider.
   (3) Licensed residential group care setting.
   (4) Licensed psychiatric medical institution for children (PMIC).
   (5) Provider accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide behavioral health services.
   (6) Provider accredited by the Council on Accreditation for behavioral health or child, youth and family services.
   (7) Provider accredited by the Joint Commission for behavioral health care services.
   (8) Provider accredited under 441—Chapter 24 to deliver services to persons with mental illness.

b. An integrated health home may include multiple sites when those sites are identified as a single organization or medical group that shares policies, procedures, and electronic systems across all of the single organization’s or medical group’s practice sites.

c. An integrated health home must complete a self-assessment when enrolling as a new health home and annually thereafter.

d. An integrated health home must meet the requirements, qualifications, and standards outlined in the integrated health home state plan amendment.

e. An integrated health home must participate in monthly, quarterly, and annual outcomes data collection and reporting.

f. At a minimum, an integrated health home must fill the following roles:
   (1) If serving adults:
      1. Nurse care manager. The integrated health home must have a nurse care manager who is a registered nurse or has a bachelor of science in nursing with an active Iowa nursing license in accordance with rule 655—3.3(17A,147,152,272C).
      2. Care coordinator. The integrated health home must have a care coordinator who has a bachelor of science in social work or a bachelor of science or bachelor of arts degree in a related field.
3. Trained peer support specialist. The integrated health home must have a peer support specialist who has completed a department-recognized training program and passed the competency examination within six months of hire.

   (2) If serving children:
      1. Nurse care manager. The integrated health home must have a nurse care manager who is a registered nurse or has a bachelor of science in nursing with an active Iowa nursing license in accordance with rule 655—3.3(17A,147,152,272C).
      2. Care coordinator. The integrated health home must have a care coordinator who has a bachelor of science in social work or bachelor of science or bachelor of arts degree in a related field.
      3. Family peer support specialist. The integrated health home must have a family peer support specialist who has completed a department-recognized training program and passed the competency examination within six months of hire.

77.47(4) Lead entity qualifications.
   a. A lead entity must meet the following requirements:
      (1) The lead entity must be licensed and in good standing in the state of Iowa as a health maintenance organization in accordance with 191—Chapter 40.
      (2) The lead entity must have a statewide integrated network of providers to serve members with serious mental illness and serious emotional disturbance.
      (3) The lead entity must complete a self-assessment at the time of enrollment and annually thereafter.
      (4) The lead entity must meet requirements, qualifications, and standards outlined in the state plan.
      (5) The lead entity must participate in monthly, quarterly, and annual outcomes data collection and reporting.
   b. At a minimum, a lead entity must fill the following roles:
      (1) Physician. The lead entity must have at least one physician to support the health home in meeting provider standards. The physician must have an active Iowa license to practice medicine in accordance with 653—Chapter 9 and be credentialed with at least one managed care organization.
      (2) Nurse care managers. The lead entity must have nurse care managers to support the health home in meeting provider standards. A nurse care manager must be a registered nurse or have a bachelor of science in nursing with an active Iowa nursing license in accordance with rule 655—3.3(17A,147,152,272C).
      (3) Social workers. The lead entity must have a care coordinator with a bachelor of science or bachelor of arts degree in social work or a related field, including sociology, counseling, psychology, or human services, to support the health home in meeting the provider standards and delivering health home services.
      (4) Behavioral health professionals. The lead entity must have a psychiatrist to support the health home in meeting provider standards and to deliver health home services. The psychiatrist must have an active Iowa license to practice medicine in accordance with 653—Chapter 9 and be credentialed with at least one managed care organization.

77.47(5) Health home general requirements.
   a. Whole person orientation. The health home is responsible for providing whole person care.
      (1) The health home must provide or take responsibility for appropriately arranging care with other qualified professionals for all the member’s health care needs. This includes care for all stages of life, including acute care, chronic care, preventive services, long-term care, and end-of-life care.
      (2) The health home must complete status reports to document the member’s housing, legal status, employment status, education, custody, and other social determinants of health, as applicable.
      (3) The health home must implement a formal screening tool to assess behavioral health, including mental health and substance abuse treatment needs, along with physical health care needs.
      (4) The health home must work with the lead entity or Iowa Medicaid to develop capacity to receive members redirected from emergency departments, engage in planning transitions in care with area hospitals, and follow up on hospital discharges, including psychiatric medical institutions for children.
(5) The health home must provide bidirectional and integrated primary care and behavioral health services through use of a contract, memoranda of agreement, or other written agreements approved by the department.

(6) The health home must, at the time of enrollment and reenrollment, provide letters of support from at least one area hospital and two area primary care practices that agree to collaborate with the health home on care coordination and hospital and emergency department notification.

(7) The health home must advocate in the community on behalf of health home members, as needed.

(8) The health home must be responsible for preventing fragmentation or duplication of services provided to members.

b. Coordinated integrated care. The health home must provide coordinated integrated care.

(1) The health home must ensure that the nurse care manager is responsible for oversight of the service, including assisting members with medication adherence, appointments, referral scheduling, tracking follow-up results from referrals, understanding health insurance coverage, reminders, transition of care, wellness education, health support or lifestyle modification, and behavior changes.

(2) The health home must utilize member-level information, member profiles, and care coordination plans for high-risk individuals.

(3) The health home must incorporate tools and evidence-based guidelines designed for identifying care opportunities across the age and diagnostic continuum, integrating clinical practices, and coordinating care with other providers.

(4) The health home must conduct interventions as indicated based on the member’s level of risk.

(5) The health home must communicate with the member, authorized representative, and the member’s family and caregivers in a culturally appropriate manner for the purposes of assessment of care decisions, including the identification of authorized representatives.

(6) The health home must monitor, arrange, and evaluate appropriate evidence-based and evidence-informed preventive services.

(7) The health home must coordinate or provide access to the following services:

1. Mental health.
2. Oral health.
3. Long-term care.
4. Chronic disease management.
5. Recovery services and social health services available in the community.
6. Behavior modification interventions aimed at supporting health management, including but not limited to obesity counseling, tobacco cessation, and health coaching.
7. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up.

8. Crisis services.

(8) The health home must assess social, educational, housing, transportation, and vocational needs that may contribute to disease and present as barriers to self-management.

(9) The health home must coordinate with community-based case managers, case managers, and service coordinators for members who receive service coordination activities.

(10) The health home must maintain a system and written standards and protocols for tracking member referrals.

c. Enhanced access. The health home must provide enhanced access for members and member caregivers, including access to health home services 24 hours per day, seven days per week. The health home must use email, text messaging, patient portals and other technology to communicate with members based on the member’s preferred method of communication.

d. Emphasis on quality and safety. The health home must emphasize quality and safety in the delivery of health home services.

(1) The health home must have an ongoing quality improvement plan to address gaps and identify opportunities for improvement.

(2) The health home must participate in ongoing process improvement on clinical indicators and overall cost-effectiveness.
(3) The health home must demonstrate continuing development of fundamental health home functionality through an assessment process applied by the department.

(4) The health home must have strong, engaged organizational leadership that is personally committed to and capable of:
   1. Leading the health home through the transformation process and sustaining transformed practice, and
   2. Participating in learning activities including in-person sessions, webinars, and regularly scheduled meetings.

(5) The health home must participate in or convene ad hoc or scheduled meetings with lead entities and the department to plan and discuss implementation of goals and objectives for practice transformation, with ongoing consideration of the unique practice needs for adult members with a serious mental illness and child members with a serious emotional disturbance and those members’ families.

(6) The health home must participate in Centers for Medicare and Medicaid Services (CMS)- and department-required evaluation activities.

(7) The health home must submit information as requested by the department.

(8) The health home must maintain compliance with all of the terms and conditions of the integrated health home or chronic condition health home provider agreement.

(9) The health home must use an interoperable patient registry and certified electronic health record within a timeline approved by the lead entity or the department to input clinical information, track and measure care of members, automate care reminders, and produce exception reports for care planning.

(10) The health home must complete web-based member enrollment, disenrollment, members’ consent to release of information, and health risk questionnaires for all members.

(11) The health home must use a certified electronic health record to support clinical decision-making within the practice workflow and establish a plan to meaningfully use health information in accordance with the federal law.

(12) The health home must implement state-required disease management programs based on population-specific disease burdens. The health home may choose to identify and operate additional disease management programs at any time.
   
   e. Case management. The integrated health home must provide case management services as defined in and required by 441—Chapter 90 to eligible members in an integrated health home. Requirements in 441—Chapter 90 are the minimum criteria for intensive care management for members enrolled in the 1915(i) Habilitation Program or the 1915(c) Children’s Mental Health Waiver.

   f. Policies and procedures. The health home must have policies and processes in place to ensure compliance with federal and state requirements, including but not limited to statutes, rules and regulations, and sub-regulatory guidance. The health home must maintain documentation of its policies and processes and make those policies and processes readily available to any state or federal officials upon request.

   g. Report on quality measures. A health home must collect and report quality data to the lead entity and the department as specified by the department.

   h. Health home termination. If the health home intends to stop providing health home services, the health home must provide notice of termination a minimum of 60 days prior to the date of termination by submitting Form 470-5465, Provider Request to Terminate Enrollment, to the department. The health home must notify members of termination 60 days prior to the termination date and provide for a seamless transition of enrollees to other health home providers.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.48(249A) Speech-language pathologists. Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.
77.48(1) Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.48(2) Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.

[ARC 0366C; IAB 10/3/12, effective 12/1/12]

441—77.49(249A) Physician assistants. All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation.

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

[ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 5418C, IAB 2/10/21, effective 4/1/21]

441—77.50(249A) Ordering and referring providers. A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider’s payment arrangements with such facilities or supervising providers.

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

[ARC 0580C, IAB 2/6/13, effective 4/1/13]

441—77.51(249A) Child care medical services. Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

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

[ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 6310C, IAB 5/4/22, effective 7/1/22]

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

77.52(1) Definitions.

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

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

“Health care” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

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

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

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

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

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

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

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

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

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

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

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

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

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

   (4) The program administrator shall be a certified brain injury specialist trainer (CBIST) through the Academy of Certified Brain Injury Specialists or a certified brain injury specialist under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441—83.81(249A) with additional certification as approved by the department. The administrator shall be present in the assigned location for 25 hours per week. In the event of an absence from the assigned location exceeding four weeks, the organization shall designate a qualified replacement to act as administrator for the duration of the assigned administrator’s absence.

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

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

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

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

      4. Be a certified brain injury specialist (CBIS) certified through the Academy for the Certification of Brain Injury Specialists (ACBIS) or have other nationally recognized brain injury certification as approved by the department.

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

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

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

      3. Quality of life issues.


      5. Health and medication management.

      6. Dietary and nutritional programming.

      7. Assistance with identifying and utilizing assistive technology.

      8. Substance abuse and addiction issues.
10. Flexibility in programming to meet members’ individual needs.
11. Teaching adaptive and compensatory strategies to address cognitive, behavioral, physical, psychosocial and medical needs.
12. Community accessibility and safety.
13. Household maintenance.
14. Service support to the member’s family or support system related to the member’s neurobehavioral care.

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

(1) Completion of the department-approved brain injury training modules.
(2) Member rights.
(3) Confidentiality and privacy.
(4) Dependent adult and child abuse prevention and mandatory reporter training.
(5) Individualized rehabilitation treatment plans.
(6) Major mental health disorder basics.

c. Within 30 days of commencement of direct service provision, employees shall complete nationally recognized cardiopulmonary resuscitation (CPR) certification, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually, with the exception of CPR certification, which must be renewed prior to expiration of the certification.

d. Within the first six months of commencement of direct service provision, employees shall complete training required by subparagraph 77.52(3)’a’(6).

e. Within 12 months of the commencement of direct service provision, employees shall complete a department-approved, nationally recognized certified brain injury specialist training. A majority of eligible employees within 12 months of the commencement of direct service provision shall be CBISs certified through ACBIS or have other nationally recognized brain injury certification as approved by the department.

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

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

(1) Measure and analyze organizational activities and services quarterly.
(2) Conduct satisfaction surveys with members, family members, employees and stakeholders, and share the information with the public.
(3) Conduct an internal review of member service records at regular intervals.
(4) Track major and minor incident data according to subrule 77.37(8) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof; and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.
(5) Continuously identify areas in need of improvement.
(6) Develop a plan to address the identified areas in need of improvement.
(7) Implement the plan, document the results, and report to the governing body annually.

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

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

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

(1) Members are valued.

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

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

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

(5) When a member requires any restrictive interventions, the interventions will be implemented in accordance with rules 481—63.21(135C), 481—63.27(135C), and 481—63.28(135C). When a member has a guardian or legal representative, the guardian or legal representative shall provide informed consent to treat and consent for any restrictive interventions that may be required to protect the health or safety of the member. Restrictive interventions include but are not limited to:

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

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

3. Exclusionary time out;

4. Intensive staffing for control of behavior;

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

6. Reprimand;

7. Response cost; and

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

(6) Members receive individualized services.

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

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

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

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

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

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

[ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—77.53(249A) Qualified Medicare beneficiary (QMB) providers. Any Medicare provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a QMB provider.

77.53(1) Reimbursement. A QMB provider may only bill the department for the QMB-eligible member’s Medicare cost-sharing obligations. Reimbursement is limited to coinsurance, copayments, and deductibles for Medicare-covered services.

77.53(2) Definitions.

“Coinsurance” means a percentage of costs of a covered health care service that has to be paid.
“Copayment” means a fixed amount a member pays for a covered health care service. “Deductible” means the amount paid for covered health care services before the insurance plan will effect payment.

“Medicare cost sharing” means the Medicare member’s responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“Qualified Medicare beneficiary” or “QMB” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

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

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—77.54(249A) Health insurance premium payment (HIPP) providers. Any provider not enrolled as an Iowa Medicaid provider for the general Medicaid population may enroll to be a HIPP provider. A HIPP provider may bill the department for the HIPP-eligible member’s out-of-pocket cost-sharing obligations. Reimbursement is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member’s health insurance paid for through the HIPP program.

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

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—77.55(249A) Crisis response services.

77.55(1) Definitions. The terms used in this rule shall have the same meaning as set out in 441—Chapter 24, Division II.

77.55(2) Eligible providers. Agencies which are accredited under the mental health service provider standards established by the mental health and disability services commission, set forth in 441—Chapter 24, Division II, are eligible to participate in the program by providing crisis response services, crisis stabilization community-based services, and crisis stabilization residential services.

77.55(3) Provider standards. All providers of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services shall meet the standards criteria as set forth in 441—Chapter 24, Division II.

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

[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—77.56(249A) Subacute mental health services.

77.56(1) Definitions. The terms used in this rule shall have the same meaning as set out in Iowa Code section 135G.1.

77.56(2) Subacute mental health services. Subacute mental health services are intended to be short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.

77.56(3) Eligible provider. Subacute mental health care facilities which are licensed by the department of inspections and appeals in accordance with 481—Chapter 71 are eligible to participate in the program by providing subacute mental health services.

77.56(4) Provider standards. All providers of subacute mental health services shall meet the standards criteria as set forth in 481—Chapter 71.

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

[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—77.57(249A) Pharmacists. An authorized pharmacist licensed to practice in the state of Iowa is eligible to participate in the program.

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

[ARC 5175C, IAB 9/9/20, effective 6/1/21]

[Filed 3/11/70, amended 6/21/73, 2/13/75, 3/21/75]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
[Filed 2/8/78, Notice 12/28/78—published 3/8/78, effective 4/12/78]
[Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]
[Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]
[Filed 5/20/83, Notice 3/30/83—published 6/8/83, effective 8/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
[Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 1/1/89]
[Filed 12/8/88, Notice 10/19/88—published 12/28/88, effective 2/1/89]
[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
[Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
[Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]
[Filed 4/13/90, Notice 11/29/90—published 5/2/90, effective 8/1/90]
[Filed 7/13/90, Notice 5/16/90—published 8/8/90, effective 10/1/90]
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
[Filed 1/17/91, Notice 11/14/90—published 2/6/91, effective 4/1/91]
[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
[Filed 6/14/91, Notice 5/1/91—published 7/10/91, effective 9/1/91]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
[Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92]
[Filed emergency 5/13/92 after Notice 4/1/92—published 6/10/92, effective 5/14/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
[Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed 8/12/93, Notices 4/28/93, 7/7/93—published 9/1/93, effective 11/1/93]
[Filed emergency 12/16/93 after Notice 10/27/93—published 1/5/94, effective 1/1/94]
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed emergency 2/10/94 after Notice 1/5/94—published 3/2/94, effective 3/1/94]
[Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
[Filed 12/15/94, Notice 11/9/94—published 1/4/95, effective 3/5/95]
[Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
[Filed 11/16/95, Notices 8/2/95, 9/13/95, 9/27/95—published 12/6/95, effective 2/1/96]
[Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]
[Filed 10/9/96, Notice 8/14/96—published 11/6/96, effective 1/1/97]
[Filed 2/12/97, Notice 12/18/96—published 3/12/97, effective 5/1/97]
[Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
[Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
After 7/1/01, Notice 10/1/01, effective 1/1/01
12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01
2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01
Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01
Filed emergency 6/13/01—published 7/11/01, effective 7/1/01
Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01
Filed 11/14/01, Notice 10/3/01—published 12/12/01, effective 2/1/02
Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02
Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02
Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02
Filed 1/9/02, Notice 11/14/01—published 2/6/02, effective 4/1/02
Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02
Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02
Filed emergency 11/18/02—published 12/11/02, effective 12/15/02
Filed emergency 6/12/03—published 7/9/03, effective 7/1/03
Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03
Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04
Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04
Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05
Filed emergency 9/21/05—published 10/12/05, effective 10/1/05
Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06
Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06
Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06
Filed emergency 9/14/06—published 10/11/06, effective 10/1/06
Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06
Filed emergency 12/13/06—published 1/3/07, effective 1/1/07
Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07
Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07
Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07
Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07
Filed 6/11/08, Notice 4/23/08—published 7/2/08, effective 9/1/08
Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08
Filed 11/12/08, Notice 9/24/08—published 12/3/08, effective 2/1/09
Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09
Filed ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, effective 7/1/09
Filed ARC 7936B (Notice ARC 7653B, IAB 3/25/09), IAB 7/1/09, effective 9/1/09
Filed ARC 9314B (Notice ARC 9112B, IAB 10/6/10), IAB 12/29/10, effective 3/1/11
Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11, effective 4/1/11
Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11
Filed Emergency After Notice ARC 9649B (Notice ARC 9538B, IAB 6/1/11), IAB 8/10/11, effective 8/1/11
Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12
[Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective 7/1/12]
[Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]
[Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0485C (Notice ARC 0259C, IAB 8/8/12), IAB 12/12/12, effective 2/1/13]
[Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]
[Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
[Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]

[Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]
[Filed Emergency After Notice ARC 0848C, IAB 7/24/13, effective 7/1/13]
[Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13]
[Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1149C (Notice ARC 0911C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1445C (Notice ARC 1366C, IAB 3/5/14), IAB 4/30/14, effective 7/1/14]
[Filed ARC 1638C (Notice ARC 1553C, IAB 7/23/14), IAB 10/1/14, effective 11/5/14]
[Filed ARC 1698C (Notice ARC 1618C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
[Filed ARC 1807C (Notice ARC 1707C, IAB 10/29/14), IAB 1/7/15, effective 3/1/15]
[Filed ARC 2165C (Notice ARC 2061C, IAB 7/22/15), IAB 9/30/15, effective 12/1/15]
[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
[Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
[Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]
[Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]
[Filed ARC 3184C (Notice ARC 2920C, IAB 2/1/17), IAB 7/5/17, effective 8/9/17]
[Filed ARC 3494C (Notice ARC 3321C, IAB 9/27/17), IAB 12/6/17, effective 1/10/18]
[Filed ARC 3551C (Notice ARC 3439C, IAB 11/8/17), IAB 1/3/18, effective 2/7/18]
[Filed ARC 3789C (Notice ARC 3659C, IAB 2/28/18), IAB 5/9/18, effective 7/1/18]
[Filed ARC 3874C (Notice ARC 3784C, IAB 5/9/18), IAB 7/4/18, effective 8/8/18]
[Filed ARC 4165C (Notice ARC 4031C, IAB 9/26/18), IAB 12/5/18, effective 1/9/19]
[Filed ARC 4792C (Notice ARC 4628C, IAB 8/28/19), IAB 12/4/19, effective 1/8/20]
[Filed ARC 5175C (Notice ARC 4964C, IAB 3/11/20), IAB 9/9/20, effective 6/1/21]
[Filed ARC 5307C (Notice ARC 5166C, IAB 9/9/20), IAB 12/2/20, effective 2/1/21]
[Filed ARC 5361C (Notice ARC 5230C, IAB 10/21/20), IAB 12/30/20, effective 3/1/21]
[Filed ARC 5418C (Notice ARC 5276C, IAB 11/18/20), IAB 2/10/21, effective 4/1/21]
[Filed ARC 5809C (Notice ARC 5623C, IAB 5/19/21), IAB 7/28/21, effective 9/1/21]
[Filed ARC 5889C (Notice ARC 5706C, IAB 6/16/21), IAB 9/8/21, effective 11/1/21]
[Filed ARC 6310C (Notice ARC 6206C, IAB 2/23/22), IAB 5/4/22, effective 7/1/22]
[Filed ARC 6388C (Notice ARC 6300C, IAB 4/20/22), IAB 6/29/22, effective 9/1/22]

1 Two ARC
2 December 15, 2002, effective date of 77.37(14) "e" (2) and 77.39(13) "e" delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.
CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES
[ Prior to 7/1/83, Social Services[770] Ch 78]
[ Prior to 2/11/87, Human Services[498]]

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

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

78.1(1) Payment will not be made for:

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

b. Reserved.

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

d. Acupuncture treatments.

e. Reserved.

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

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

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

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

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

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

(1) Colostomy and ileostomy appliances.

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

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.
c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Reserved.

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

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

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

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

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

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

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

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

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

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

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

1. Correction of a congenital anomaly; or
2. Restoration of body form following an accidental injury; or
3. Revision of disfiguring and extensive scars resulting from neoplastic surgery.
4. Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

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

1. Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.
(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

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

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

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

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

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

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

3. Augmentation mammoplasties.

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

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

6. Panniculectomy and body sculpture procedures.

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

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

9. Chemical peeling for facial wrinkles.

10. Dermabrasion of the face.

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


13. Hair transplants.


15. Sex reassignment.


17. Insertion of prosthetic testicles.

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

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

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

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

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

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:
a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

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

c. Payment will be approved for mileage in connection with nursing home visits when:
   (1) It is necessary for the physician to travel outside the home community, and
   (2) There are not physicians in the community in which the nursing home is located.

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

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

78.1(11) Reserved.

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

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

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

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

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

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

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

A physician assistant licensed under board of physician assistants’ professional licensure rules in 645—Chapters 326 to 329 is exempt from the direct personal supervision requirement except as expressly required by Iowa Code chapter 148C or required by rules in 645—Chapters 326 to 329. A physician shall be accessible at all times for consultation with a physician assistant unless the physician assistant is providing emergency medical services pursuant to 645—paragraph 327.1(2)“n.” Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).
d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician’s professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

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

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

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

a. The following definitions are pertinent to this subrule:

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.
f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

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

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

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

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

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

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

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

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

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

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

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

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

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

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

78.1(20) Transplants.

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

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

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

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

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

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

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

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

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1)”f”)

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

6. Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1)”f”)

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

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

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

2. Pancreas transplants alone are covered for persons exhibiting any of the following:
   - A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
   - Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
   - Consistent failure of insulin-based management to prevent acute complications.
The pancreas transplants listed under this subparagraph require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1)“f”)

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

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

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

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

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

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

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

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

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

78.1(23) Reserved.

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

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

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

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

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

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

This rule is intended to implement Iowa Code section 249A.4.
[ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0846C, IAB 7/24/13, effective 7/1/13; ARC 1052C, IAB 10/2/13, effective 11/6/13; ARC 1297C, IAB 2/5/14, effective 4/1/14; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5418C, IAB 2/10/21, effective 4/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]
441—78.2(249A) Prescribed outpatient drugs. Payment will be made for “covered outpatient drugs” as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

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

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

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

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

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

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

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

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

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

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

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

b. Payment is not made for:

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

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

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

(4) Reserved.

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

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

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

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

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

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

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

78.2(5) Nonprescription drugs.

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

- Acetaminophen tablets 325 mg, 500 mg
- Acetaminophen elixir 160 mg/5 ml
- Acetaminophen solution 100 mg/ml
- Acetaminophen suppositories 120 mg
- Artificial tears ophthalmic solution
- Artificial tears ophthalmic ointment
- Aspirin tablets 81 mg, chewable
- Aspirin tablets 81 mg, 325 mg, and 650 mg oral
- Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
- Aspirin tablets, buffered 325 mg
- Bacitracin ointment 500 units/gm
- Benzoyl peroxide 5%, gel, lotion
- Benzoyl peroxide 10%, gel, lotion
- Cetirizine hydrochloride liquid 1 mg/ml
- Cetirizine hydrochloride tablets 5 mg
- Cetirizine hydrochloride tablets 10 mg
- Chlorpheniramine maleate tablets 4 mg
- Clotrimazole vaginal cream 1%
- Diphenhydramine hydrochloride capsules 25 mg
- Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
- Epinephrine racemic solution 2.25%
- Ferrous sulfate solution 75 mg/0.6 ml (15 mg/0.6 ml elemental iron)
- Ferrous sulfate tablets 325 mg
- Ferrous sulfate elixir 220 mg/5 ml
- Ferrous sulfate drops 75 mg/0.6 ml
- Ferrous gluconate tablets 325 mg
- Ferrous fumarate tablets 325 mg
- Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
- Ibuprofen suspension 100 mg/5 ml
- Ibuprofen tablets 200 mg
- Insulin
- Lactic acid (ammonium lactate) lotion 12%
- Levonorgestrel 1.5 mg
- Loperamide hydrochloride liquid 1 mg/5 ml
- Loperamide hydrochloride liquid 1 mg/7.5 ml
- Loperamide hydrochloride tablets 2 mg
- Loratadine syrup 5 mg/5 ml
Loratadine tablets 10 mg
Magnesium hydroxide suspension 400 mg/5 ml
Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
Miconazole nitrate cream 2% topical and vaginal
Miconazole nitrate vaginal suppositories, 100 mg
Mineral products with prior authorization
Neomycin-bacitracin-polymyxin ointment
Nicotine gum 2 mg, 4 mg
Nicotine lozenge 2 mg, 4 mg
Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
Pediatric oral electrolyte solutions
Permethrin lotion 1%
Polyethylene glycol 3350 powder
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pyrethrins-piperonyl butoxide liquid 0.33-4%
Pyrethrins-piperonyl butoxide shampoo 0.3-3%
Pyrethrins-piperonyl butoxide shampoo 0.33-4%
Salicylic acid liquid 17%
Senna tablets 187 mg
Sennosides-docusate sodium tablets 8.6 mg-50 mg
Sennosides syrup 8.8 mg/5 ml
Sennosides tablets 8.6 mg
Sodium bicarbonate tablets 325 mg
Sodium bicarbonate tablets 650 mg
Sodium chloride hypertonic ophthalmic ointment 5%
Sodium chloride hypertonic ophthalmic solution 5%
Tolnaftate 1% cream, solution, powder
Vitamins, single and multiple with prior authorization
Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

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

78.2(6) Quantity prescribed.

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

b. Prescription refills.

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

(2) Automatic refills.

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

2. The program must have:
   ● Easy-to-locate contact information through telephone, the program’s website, or both;
   ● Easy-to-understand patient materials on how to select or unselect drug(s) for inclusion and how to disenroll;
   ● Confirmation that the member wants to continue in the automatic refill program at least annually;
   ● Confirmation of continued medical necessity provided by the Medicaid member or person acting as an authorized representative of the member, before the member receives the medication at the
pharmacy or before the medication is mailed or delivered to the member, without which confirmation
the drug(s) must be credited back to the Medicaid program; and

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

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

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

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

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11; ARC 9699B, IAB 9/7/11, effective 9/1/11;
ARC 9834B, IAB 11/2/11, effective 11/1/11; ARC 9982B, IAB 11/30/11, effective 1/4/12; ARC 9981B, IAB 2/8/12, effective 3/14/12;
ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16;
ARC 2930C, IAB 2/1/17, effective 4/1/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC
5175C, IAB 9/9/20, effective 6/1/21; ARC 5364C, IAB 12/30/20, effective 3/1/21]

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

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

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

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

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

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

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

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

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

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

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

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have
been certified by the department of inspections and appeals as meeting the standards for a nursing facility.
78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient’s condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient’s diagnosis or treatment.

78.3(8) Reserved.

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

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

a. Recipient selection and education.

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

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

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

b. Staffing and resource commitment.

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

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

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

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

The team should consist of:

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

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

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

Anesthesiology.
Cardiology.
Dialysis.
Gastroenterology.
Hepatology.
Immunology.
Infectious diseases.
Nephrology.
Neurology.
Pathology.
Pediatrics.
Psychiatry.
Pulmonary medicine.
Radiology.
Rehabilitation medicine.
Liaison with the recipient’s permanent physician is established for the purpose of providing continuity and management of the recipient’s long-term care.

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

- Persons with expertise in the following areas available at the transplant center:
  - Anesthesiology.
  - Blood bank services.
  - Cardiology.
  - Cardiovascular surgery.
  - Dialysis.
  - Dietary services.
  - Gastroenterology.
  - Infection control.
  - Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).
  - Legal counsel familiar with transplantation laws and regulations.
  - Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.
  - Respiratory therapy.
  - Pharmaceutical services.
  - Physical therapy.
  - Psychiatry.
  - Psycho-social.

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

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

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

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

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

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

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

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

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

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

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

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

- Risk and benefit.
- Morbidity and mortality.
- Long-term survival.
- Quality of life.
- Recipient demographic information.

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

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

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

Ongoing research regarding the transplanted organs is required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)”f”(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)”f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

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

1. The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.
2. The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16)”a.”
3. The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).
4. As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:
   1. Complete a level of care (LOC) determination describing a member’s LOC needs, using Form 470-5156, Swing Bed Certification.
   2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member’s LOC needs.
   3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member’s needs and that home-based care for the member is not available or appropriate.
   5. Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an “appropriate” nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member’s medical condition and corresponding LOC needs.
6. A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

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

78.3(17) Reserved.

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

This rule is intended to implement Iowa Code section 249A.4.
441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

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

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

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

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

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

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

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

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

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

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

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

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

i. Temporomandibular joint radiograph.

j. Cephalometric film.

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

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

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

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

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

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

1. Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.
2. Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.
3. Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.
4. Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

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

Payment as indicated will be made for the following restoration procedures:
1. Amalgam or acrylic buildups, including any pins, are considered a core buildup.
2. One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.
3. Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.
4. Reserved.
5. Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).
6. Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.
7. Pin retention will be paid on a per-tooth basis and in addition to the final restoration.
8. More than four surfaces on an amalgam restoration will be reimbursed as a “four-surface” amalgam.
9. An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

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

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

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

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.
d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross reference 78.28(3) “a”(2))

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

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

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

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

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

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

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

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

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

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

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

a. Extractions, both surgical and nonsurgical.

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

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

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

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

f. Oral antral fistula closure (or antral root recovery).
78.4(7) Prosthetic services. Payment may be made for the following prosthetic services:

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

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

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

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

(1) Have a physical or mental condition that precludes the use of a removable partial denture, or

(2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay. High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross reference 78.28(3)“b”(2))

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

(1) Have a physical or mental condition that precludes the use of a removable partial denture, or

(2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion. High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

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

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

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

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

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

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

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

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

78.4(8) Orthodontic procedures. Payment may be made for the following orthodontic procedures:
   a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross reference 78.28(3)“c”)
   b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.
   c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above using the index from the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

78.4(9) Adjunctive general services. Payment may be made for the following:
   a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.
   b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.
   c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.
   d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.
   e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist’s office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.
   f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.
   g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

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

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

78.4(12) Annual benefit maximum.
   a. Members 21 years of age or older have an annual benefit maximum of $1,000 per state fiscal year for coverage of dental services set forth in this rule. Payment for services exceeding the $1,000 annual benefit maximum is the responsibility of the member.
   b. The following services do not count toward the annual benefit maximum:
      (1) Preventive services as set forth in subrule 78.4(1);
      (2) Diagnostic services as set forth in subrule 78.4(2);
(3) Fabrication of removable dentures and related services as set forth in paragraphs 78.4(7) “a” to “c” and 78.4(7) “f” to “l”;
(4) Anesthesia as set forth in paragraph 78.4(9) “f” when provided in conjunction with oral surgery codes approved for payment; or
(5) Emergency services as set forth in subrule 78.4(11).

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

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

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

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:
   a. Durable plantar foot orthotic.
   b. Plaster impressions for foot orthotic.
   c. Molded digital orthotic.
   d. Shoe padding when appliances are not practical.
   e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.
   f. Rams horn (hypertrophic) nails.
   g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:
   a. Treatment of flatfoot. The term “flatfoot” is defined as a condition in which one or more arches have flattened out.
   b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.
   Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.
   c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.
   d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

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

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

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

78.6(1) Payable professional services. Payable professional services are:
   a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye
disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

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

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

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

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

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

2. Gonioscopy.

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

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

5. External photography.

6. Fundus photography.

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

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

1. When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:
   1. Ordering of corrective lenses.
   2. Verification of lenses after fabrication.
   3. Adjustment and alignment of completed lens order.

2. New spectacle lenses are subject to the following limitations:
   1. Up to three times for children up to one year of age.
   2. Up to four times per year for children one through three years of age.
   3. Once every 12 months for children four through seven years of age.
   4. Once every 24 months after eight years of age when there is a change in the prescription.

3. Spectacle lenses made from polycarbonate or equivalent material are allowed for:
   1. Children through seven years of age.
   2. Members with vision in only one eye.
   3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Reserved.

f. Frame service.

1. When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:
   1. Selection and styling.
2. Sizing and measurements.
3. Fitting and adjustment.
4. Readjustment and servicing.

(2) New frames are subject to the following limitations:
1. One frame every six months is allowed for children through three years of age.
2. One frame every 12 months is allowed for children four through seven years of age.
3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:
1. Children through seven years of age.
2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.
3. Reserved.
4. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.
5. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member’s vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:
   (1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.
   (2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.
   (3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.
   (4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.
   (5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) Ophthalmic materials. Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:
   a. Corrected curve lenses, unless clinically contraindicated.
   b. Standard plastic, plastic and metal combination, or metal frames.
   c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) Reimbursement. The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.
   a. Materials payable by fee schedule are:
      (1) Spectacle lenses, single vision and multifocal.
      (2) Frames.
      (3) Case for glasses.
   b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:
      (1) Contact lenses.
      (2) Schroeder shield.
      (3) Ptosis crutch.
      (4) Safety frames.
      (5) Subnormal visual aids.
      (6) Photochromatic lenses.

78.6(4) Prior authorization. Prior authorization is required for the following:
a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member’s vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

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

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

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

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

(Cross reference 78.28(4))

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

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

b. Glasses for occupational eye safety.

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Sunglasses.

f. Progressive bifocal or trifocal lenses.

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

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

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

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

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

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

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

78.8(2) Indications and limitations of coverage.

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

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

c. CMT is not covered benefit when:

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

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

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

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

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which
major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph “a” of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph “a” of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor’s office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

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

[ARC 2164C; IAB 9/30/15; effective 10/1/15]

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant in a plan of home care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member’s residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10) “a” may be provided in settings other than the member’s residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient’s care, e.g., syringes for injections, and do not exceed $15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member’s community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, nurse practitioner, clinical nurse specialist, or physician assistant, evidenced by the physician’s, nurse practitioner’s, clinical nurse specialist’s, or physician assistant’s signature and date on a plan of treatment.

78.9(1) Treatment plan. A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. The
A plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

a. Place of service.
b. Type of service to be rendered and the treatment modalities being used.
c. Frequency of the services.
d. Assistance devices to be used.
e. Date home health services were initiated.
g. Medical supplies to be furnished.
h. Member’s medical condition as reflected by the following information, if applicable:
   (1) Dates of prior hospitalization.
   (2) Dates of prior surgery.
   (3) Date last seen by a physician, nurse practitioner, clinical nurse specialist, or physician assistant.
   (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
   (5) Prognosis.
   (6) Functional limitations.
   (7) Vital signs reading.
   (8) Date of last episode of instability.
   (9) Date of last episode of acute recurrence of illness or symptoms.
   (10) Medications.
   i. Discipline of the person providing the service.
   j. Certification period (no more than 60 days).
   k. Estimated date of discharge from the hospital or home health agency services, if applicable.
   l. Physician’s, nurse practitioner’s, clinical nurse specialist’s, or physician assistant’s signature and date. The plan of care must be signed and dated by the physician, nurse practitioner, clinical nurse specialist, or physician assistant before the claim for service is submitted for reimbursement.

78.9(2) Supervisory visits. Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department’s in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) Skilled nursing services. Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a “skilled nursing service.” Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician’s, nurse practitioner’s, clinical nurse specialist’s, or physician assistant’s estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician, nurse practitioner, clinical nurse specialist, or a physician assistant and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.
Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) **Physical therapy services.** Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient’s illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs “a” and “b.”

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) **Occupational therapy services.** Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant, are reasonable and necessary to the treatment of the patient’s illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs “a” and “c.”

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) **Speech therapy services.** Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, nurse practitioner, clinical nurse specialist, or physician assistant, are reasonable and necessary to the treatment of the patient’s illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs “a” and “d.”

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) **Home health aide services.** Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician, nurse practitioner, clinical nurse specialist, or physician assistant. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child’s caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. “Intermittent basis” for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member’s institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or
housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) Medical social services. Rescinded IAB 3/29/17, effective 5/3/17.

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

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

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

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

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

78.9(10) Private duty nursing or personal care services for persons aged 20 and under: Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.
   a. Definitions.
      (1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member’s physician to a member in the member’s place of residence or outside the member’s residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

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

Private duty nursing or personal care services do not include:
   1. Respite care, which is a temporary intermission or period of rest for the caregiver.
   2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
   3. Services provided to other persons in the member’s household.
   4. Services requiring prior authorization that are provided without regard to the prior authorization process.
   5. Transportation services.
6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse’s aide and which are delegated and supervised by a registered nurse under the direction of the member’s physician to a member in the member’s place of residence or outside the member’s residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member’s plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child’s caregiver, in the development and implementation of the plan of treatment.

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

b. Requirements.

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

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

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

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

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

78.9(1) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11; ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 3005C, IAB 3/29/17, effective 5/3/17; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5487C, IAB 3/10/21, effective 4/14/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

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

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

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member’s medical condition.
b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

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

   (2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

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

   For items requiring prior authorization, a request shall include a physician’s, physician assistant’s, or advanced registered nurse practitioner’s written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made using Form 470-5595, Outpatient Prior Authorization Request. See rule 441—78.28(249A) for prior authorization requirements.

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

   (1) Physical fitness equipment, e.g., an exercycle, weights.

   (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.

   (3) Self-help devices, e.g., safety grab bars, raised toilet seats.

   (4) Training equipment, e.g., speech teaching machines, braille training texts.

   (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

   (6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

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

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

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

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

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

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

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.
h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member’s condition.

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

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

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

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

EXCEPTIONS:

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

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

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

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

      • The initial, periodic and ending reading on the time meter clock on each oxygen system, and

      • The dates of each initial, periodic and ending reading, and

      • Evidence of ongoing need for oxygen services.

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

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

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

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

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

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

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

Automated medication dispenser.
Bathtub/shower chair, bench. See 78.10(5)“g” and “j” for prior authorization requirements.
Commode, shower commode chair. See 78.10(5)“j” for prior authorization requirements.
Decubitus equipment.
Dialysis equipment.
Diaphragm (contraceptive device).
Enclosed bed. See 78.10(5)“a” for prior authorization requirements.
Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.
Heat/cold application device.
Hospital bed and accessories.
Inhalation equipment. See 78.10(5)“e” for prior authorization requirements.
Insulin infusion pump. See 78.10(5)“b” and 78.10(5)“e” for prior authorization requirements.
Lymphedema pump.
Mobility device and accessories. See 78.10(5)“i” for prior authorization requirements.
Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in 78.10(2) “a” and 78.10(2) “c.”
Patient lift. See 78.10(5) “h” for prior authorization requirements.
Phototherapy bilirubin light.
Protective helmet.
Seat lift chair.
Speech generating device. See 78.10(5) “f” for prior authorization requirements.
Traction equipment.
Ventilator.
c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

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

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

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

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

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

6. Oxygen prescribed “PRN” or “as necessary” is not allowed.

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

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

2. Standard manual wheelchair accessories that are separately billable and require prior authorization include the following:
   1. Headrest extensions;
   2. One-arm drive attachments;
3. Positioning accessories;
4. Specialized skin protection seat and back cushions; and
5. Anti-rollback devices.

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

(4) Standard power wheelchair accessories that are billed separately and require a prior authorization include the following:
1. Shoulder harness/straps or chest straps/vest;
2. Elevating legrest;
3. Angle adjustable footplates;
4. Adjustable height armrests; and
5. Expandable controller or nonstandard joystick (i.e., non-proportional or mini, compact or short throw proportional, or other alternative control device).

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

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

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

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

(1) Artificial eyes.
(2) Artificial limbs.
(3) Enteral delivery supplies and products. See 78.10(5)“l” for prior authorization requirements.
(4) Hearing aids. See rule 441—78.14(249A).
(5) Orthotic devices. See 78.10(3)“e” for limitations on coverage of cranial orthotic devices.
(6) Ostomy appliances.
(7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member’s general condition.
(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).
(9) Tracheotomy tubes.
(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference 78.28(5))
   c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:
   (1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or
   (2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:
       1. Cephalic index at least two standard deviations above the mean for the member’s gender and age; or
       2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) Medical supplies. Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member’s caregiver for each refill.
   a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:
      Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.
      Catheter (indwelling Foley).
      Colostomy and ileostomy appliances.
      Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.
      Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5)“e” for prior authorization requirements.
      Dialysis supplies.
      Disposable catheterization trays or sets (sterile).
      Disposable irrigation trays or sets (sterile).
      Disposable saline enemas (e.g., sodium phosphate type).
      Dressings.
      Elastic antiembolism support stocking.
      Enema.
      Hearing aid batteries.
      Incontinence products (for members three years of age and older).
      Oral nutritional products. See 78.10(5)“m” for prior authorization requirements.
      Ostomy appliances and supplies.
      Respirator supplies.
      Shoes, diabetic.
Surgical supplies.
Urinary collection supplies.
b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:
   Catheter (indwelling Foley).
   Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).
   Disposable catheterization trays or sets (sterile).
   Disposable irrigation trays or sets (sterile).
   Disposable saline enemas (e.g., sodium phosphate type).
   Ostomy appliances and supplies.
   Shoes, diabetic.

78.10(5) Prior authorization requirements. Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross reference 78.28(1)):
   a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:
      (1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.
      (2) The member’s mobility puts the member at risk for injury.
   b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.
   c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:
      (1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.
      (2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.
      (3) Treatment by flutter device failed or is contraindicated.
      (4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.
      (5) All other less costly alternatives have been tried.
   d. Rescinded IAB 12/30/20, effective 3/1/21.
   e. DME rebate agreements. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member’s medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.
   f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician’s, physician assistant’s, or advanced registered nurse practitioner’s prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member’s educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.
g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

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

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:
   (1) Has a sip ’n puff attachment, or
   (2) The medical documentation demonstrates the member’s difficulty operating the wheelchair in tight space, or
   (3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:
   (1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and
   (2) Needs upper body support while sitting, and
   (3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

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

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

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

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:
   (1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and
   (2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider’s cost to obtain the equipment or supply.

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

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 9/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11; ARC 0632C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

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

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient’s home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged
from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician’s confirmation when:
   a. The individual is admitted as a hospital inpatient or in an emergency situation.
   b. Previous information on file relating to the patient’s condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:
   - One patient - normal allowance
   - Two patients - 3/4 normal allowance per patient
   - Three patients - 2/3 normal allowance per patient
   - Four patients - 5/8 normal allowance per patient

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

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

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

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

78.12(1) Definitions.
   “Behavioral health intervention” means skill-building services that focus on:
   1. Addressing the mental and functional disabilities that negatively affect a member’s integration and stability in the community and quality of life;
   2. Improving a member’s health and well-being related to the member’s mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member’s best possible functional level; and
   3. Promoting a member’s mental health recovery and resilience through increasing the member’s ability to manage symptoms.

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

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

   “Mental disorder” means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced
movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) Covered services.

a. Service setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Family training services shall:

1. Enhance the family’s ability to effectively interact with the child and support the child’s functioning in the home and community, and
2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:
1. Be for the direct benefit of the member, and
2. Be based on a curriculum with a training manual.
3. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.
   (1) Skill training and development shall consist of interventions to:
   1. Enhance a member’s independent living, social, and communication skills;
   2. Minimize or eliminate psychological barriers to a member’s ability to effectively manage symptoms associated with a psychological disorder; and
   3. Maximize a member’s ability to live and participate in the community.
   (2) Interventions may include training in the following skills for effective functioning with family, peers, and community:
   1. Communication skills,
   2. Conflict resolution skills,
   3. Daily living skills,
   4. Employment-related skills,
   5. Interpersonal relationship skills,
   6. Problem-solving skills, and
   7. Social skills.

78.12(3) Excluded services.
   a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, “habilitative services” means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.
   b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) Coverage requirements. Medicaid covers behavioral health intervention only when the following conditions are met:
   a. A licensed practitioner of the healing arts acting within the practitioner’s scope of practice under state law has diagnosed the member with a psychological disorder.
   b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member’s psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.
      (1) The member’s need for services must meet specific individual goals that are focused to address:
         1. Risk of harm to self or others,
         2. Behavioral support in the community,
         3. Specific skills impaired due to the member’s mental illness, and
         4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.
      (2) Diagnosis and treatment plan development are covered services.
      c. For a member under the age of 21, the licensed practitioner of the healing arts:
         (1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member’s current skill level in managing mental health needs;
         (2) Has completed an initial formal assessment of the member using the instrument selected; and
         (3) Completes a formal assessment every six months thereafter if continued services are ordered.
      d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).
78.12(5) Approval of plan. The behavioral health intervention provider shall contact the member’s managed care plan for authorization of the services.

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

b. Subsequent plans. The member’s managed care plan may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)“a” if the services are recommended by a licensed practitioner of the healing arts who has:
   (1) Reexamined the member;
   (2) Reviewed the original diagnosis and treatment plan; and
   (3) Evaluated the member’s progress, including a formal assessment as required by 78.12(4)“c”(3).

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

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

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

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

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:
   (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
   (2) The professional literature regarding evidence-based practices in the field.

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

[ARC 8594B, IAB 2/10/10, effective 3/22/10; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 1850C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 6310C, IAB 5/4/22, effective 7/1/22]

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

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

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member’s needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:
   (1) Mileage reimbursement to the member, if the member is the driver.
   (2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.
   (3) Taxi service.
   (4) Public transportation when public transportation is reasonably available and the member’s condition does not preclude its use.
   (5) Wheelchair and stretcher vans.
(6) Airfare costs when the most appropriate mode of transport is by air, based on the member’s medical condition.
   b. Reimbursement for costs of the member’s meals necessary during periods of transportation and medical treatment.
   c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.
   d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.
   e. Reimbursement of a medically necessary escort’s travel expenses when an escort is required because of the member’s needs.

78.13(2) Exclusions. Nonemergency medical transportation is not available through the Iowa Medicaid program for:
   a. Transportation to obtain services not covered by Iowa Medicaid;
   b. Transportation to providers that are not enrolled in Iowa Medicaid;
   c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);
   d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;
   e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;
   f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;
   g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and
   h. Emergency transportation.

78.13(3) Conditions and limitations on covered services. Nonemergency medical transportation services are subject to the following limitations and conditions:
   a. Member request. When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days’ advance notice.
      (1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member’s appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.
      (2) If the member’s nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days’ notice impossible because of the member’s urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days’ notice. Examples of urgent trips include, but are not limited to:
        1. Postsurgical or medical follow-up care specified by a health care provider;
        2. Unexpected preoperative appointments;
        3. Hospital discharges;
        4. Appointments for new medical conditions or tests; and
        5. Dialysis.
      (3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:
        1. The member must notify the broker no later than the day of the trip;
2. The transportation must be provided by a driver with a valid driver’s license and insurance coverage on the vehicle at the time of the transport; and

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

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

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

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

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

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

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

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

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

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

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

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

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

78.13(4) Grievance procedure. The broker shall establish an internal grievance procedure for members and transportation providers.
Members may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.”

Transportation providers.

1. Consent for state fair hearing.
   1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.
   2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member’s lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.
   3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider’s bringing the state fair hearing on the member’s behalf.

2. For all transportation provider grievances not addressed by paragraph 78.13(4) "b," the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

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

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 1264C, IAB 1/8/14, effective 3/1/14; ARC 1976C, IAB 4/29/15, effective 7/1/15; ARC 6310C, IAB 5/4/22, effective 7/1/22]

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

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

a. Has been advised that it may be in the member’s best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

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

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

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

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

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:
a. A child needs the aid for speech development,
b. The aid is needed for educational or vocational purposes,
c. The aid is for a blind member,
d. The member’s hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
e. Lack of binaural amplification poses a hazard to a member’s safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.
b. Payment for ear mold and batteries shall be at the current audiologist’s fee schedule.
c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer’s depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer’s invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer’s depot and this charge is made to the general public.
d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1)“a.”
   (1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member’s hearing that would require a different hearing aid. (Cross reference 78.28(5)“a”)
   (2) Payment for a hearing aid costing more than $650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(5)“b”):
      1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.
      2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

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

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

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

78.15(1) Definitions.

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

“Depth shoe” means a shoe that:
1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:
1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient’s foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:
1. The date.
2. The patient’s diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

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

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

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:
   (1) The reasons the recipient cannot be fitted with a depth shoe.
   (2) Pain.
   (3) Tissue breakdown or a high probability of tissue breakdown.
   (4) Any limitation on walking.

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

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

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

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

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)“b” with the following exceptions:
   (1) Services by staff psychiatrists, or
   (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
   (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.
   (1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified
psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

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

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)”b”(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)”b”(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)”b”.

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

(4) Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor’s degree in a human services related field from an accredited college or university; or
(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program’s description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs “c” to “h” below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor’s degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified
occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient’s case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider’s program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient’s progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient’s condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).
(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient’s educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient’s principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient’s behavior, and must be involved in the patient’s treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient’s strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs
with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the “National Register of Health Service Providers in Psychology” or the “Iowa Register of Health Service Providers for Psychology.” Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

1. In the case of patient improvement:
   1. The patient’s clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient’s developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.
   2. Treatment goals in the individualized treatment plan have been achieved.
   3. An aftercare plan has been developed that is appropriate to the patient’s needs and agreed to by the patient and family, custodian, or guardian.

2. If the patient does not improve:
   1. The patient’s clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.
   2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

   g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

   The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

   Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

   Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

   Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

   h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient’s social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.
\[ \text{i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6). This rule is intended to implement Iowa Code section 249A.4.} \]

\[ \text{441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare). This rule is intended to implement Iowa Code section 249A.4.} \]

\[ \text{441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.} \]

\[ \text{78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.} \]

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

\[ \text{78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.} \]

\[ a. \text{ Payment will be approved for health, vision, and hearing screenings as follows:} \]

\[ (1) \text{Six screenings in the first year of life.} \]

\[ (2) \text{Four screenings between the ages of 1 and 2.} \]

\[ (3) \text{One screening a year at ages 3, 4, 5, and 6.} \]

\[ (4) \text{One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.} \]

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

\[ c. \text{ Interperiodic screenings will be approved as medically necessary.} \]

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

\[ 78.18(5) \text{ When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual’s medical record.} \]

\[ 78.18(6) \text{ Reserved.} \]

\[ 78.18(7) \text{ Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietician employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.} \]

\[ 78.18(8) \text{ Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.} \]

\[ \text{This rule is intended to implement Iowa Code section 249A.4.} \]

\[ [\text{ARC 0065C, IAB 4/4/12, effective 6/1/12}] \]

\[ \text{441—78.19(249A) Rehabilitation agencies.} \]

\[ 78.19(1) \text{ Coverage of services.} \]

\[ a. \text{ General provisions regarding coverage of services.} \]

\[ (1) \text{ Services are provided in the member’s home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. A nursing facility, an intermediate care facility for persons with an intellectual disability, or a hospital where services are provided is not considered a member’s home.} \]

\[ 1. \text{ Services provided to a member residing in a residential care facility licensed under Iowa Code section 135C.4 by the department of inspections and appeals are payable when the residential care facility submits a signed statement that the residential care facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes.} \]
2. Under no circumstances will the IME or managed care organizations (MCOs) make payments to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability. Physical, occupational, and speech therapy services for residents of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital are the responsibility of the nursing facility, intermediate care facility for persons with an intellectual disability or hospital.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient’s medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1)”b”(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.
2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.
3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient’s specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.
4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1)”b”(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient’s rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1)”b”(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person’s illness, injury, or disabling condition, be specific and effective treatment for the patient’s medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).
(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient’s condition in a reasonable amount of time based on the patient’s restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient’s injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient’s medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient’s level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient’s condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient’s condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient’s condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient’s ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient’s ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.
(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient’s progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient’s response to treatment in the recipient’s environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide’s services will not be payable.)
2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)
3. Documentation of the diagnostic therapy or trial therapy must reflect the provider’s plan for therapy and the recipient’s response.
4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy.
A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person’s daily life to the extent of the person’s abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person’s ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person’s illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person’s condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) ‘b’ (7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1) ‘b’ (8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient’s condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient’s practical,
functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss or become hard of hearing (input impairment), constitutes a covered service if reasonable and necessary to the patient’s illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)”b”(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number “5” under 78.19(1)”b”(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient’s current medical condition and functional abilities, including any disabling condition.
(2) The physician’s signature and date (within the certification period).
(3) Certification period.
(4) Patient’s progress in measurable statistics. (Refer to 78.19(1)”b”(16).)
(5) The place services are rendered.
(6) Dates of prior hospitalization (if applicable or known).
(7) Dates of prior surgery (if applicable or known).
(8) The date the patient was last seen by the physician (if available).
(9) A diagnosis relevant to the medical necessity for treatment.
(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).
(11) A brief summary of the initial evaluation or baseline.
(12) The patient’s prognosis.
(13) The services to be rendered.
(14) The frequency of the services and discipline of the person providing the service.
(15) The anticipated duration of the services and the estimated date of discharge (if applicable).
(16) Assistive devices to be used.
(17) Functional limitations.
(18) The patient’s rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.
(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).
(20) Quantitative, measurable, short-term and long-term functional goals.
(21) The period of time of a session.
(22) Prior treatment (history related to current diagnosis) if available or known.
b. The information to be included when developing plans for teaching, training, and counseling include:

(1) To whom the services were provided (patient, family member, etc.).
(2) Prior teaching, training, or counseling provided.
(3) The medical necessity of the rendered services.
(4) The identification of specific services and goals.
(5) The date of the start of the services.
(6) The frequency of the services.
(7) Progress in response to the services.
(8) The estimated length of time the services are needed.

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

[ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

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

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

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

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

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

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

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

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

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

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

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

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

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

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

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

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

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.
   a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.
   b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

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

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

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

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.
   a. Payment shall be made only for time spent in face-to-face consultation with the client.
   b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:
   a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or
   b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or
   c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.
   d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.
   e. Mileage at the same rate as in 78.1(8) when the following conditions are met:
      (1) It is necessary for the psychologist to travel outside of the home community, and
      (2) There is no qualified mental health professional more immediately available in the community, and
      (3) The member has a medical condition which prohibits travel.
   f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.
   g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:
   a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.
   b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.
   c. Psychological examinations employing unusual or experimental instrumentation.
   d. Individual and group psychotherapy without specification of condition, symptom, or complaint.
   e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Reserved.

78.24(5) The following services shall require review by a consultant to the department.
   a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.
b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) Provider qualifications.

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Reserved.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor’s degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) Services covered for all pregnant women. Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3) “b.”

78.25(3) Enhanced services covered for women with high-risk pregnancies. Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Reserved.

b. Education, which shall include as appropriate education about the following:
(1) High-risk medical conditions.
(2) High-risk sexual behavior.
(3) Smoking cessation.
(4) Alcohol usage education.
(5) Drug usage education.
(6) Environmental and occupational hazards.

(c) Nutrition assessment and counseling, which shall include:
(1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
(2) Ongoing nutritional assessment.
(3) Development of an individualized nutritional care plan.
(4) Referral to food assistance programs if indicated.
(5) Nutritional intervention.

(d) Psychosocial assessment and counseling, which shall include:
(1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
(2) A profile of the client’s family composition, patterns of functioning and support systems.
(3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

(e) A postpartum home visit within two weeks of the child’s discharge from the hospital, which shall include:
(1) Assessment of mother’s health status.
(2) Physical and emotional changes postpartum.
(3) Family planning.
(4) Parenting skills.
(5) Assessment of infant health.
(6) Infant care.
(7) Grief support for unhealthy outcome.
(8) Parenting of a preterm infant.
(9) Identification of and referral to community resources as needed.

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

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

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

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

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

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

(a) Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;
b. Are eligible for payment as physicians’ services under the circumstances specified in rule 441—78.1(249A) or as dentists’ services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference 78.28(7))

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

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

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

78.27(1) Definitions.

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

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

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

“Care coordinator” means the professional who assists members in care coordination as described in paragraph 78.53(2) “b.”

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

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

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

“Certified employment specialist” or “CES” means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

“Child and Adolescent Level of Care Utilization System” or “CALOCUS” means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation service for individuals aged 16 to 18.
"Comprehensive service plan" means an individualized, person-centered, and goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

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

"Department" means the Iowa department of human services.

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

"HCBS" means home- and community-based services.

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

"Individual placement and support" or "IPS" means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center at Westat, and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition_2-4-16.pdf. The IPS practice principles are:

1. Focus on competitive employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.

2. Zero exclusion criteria based on client choice: People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

3. Integration of rehabilitation and mental health services: IPS programs are closely integrated with mental health treatment teams.

4. Attention to worker preferences: Services are based on each person’s preferences and choices, rather than providers’ judgments.

5. Personalized benefits counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their social security, Medicaid, and other government entitlements.

6. Rapid job search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy preemployment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.

7. Systematic job development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.

8. Time-unlimited and individualized support: Job supports are individualized and continue for as long as each worker wants and needs the support.

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

“*Integrated health home services*” means the provision of services to enrolled members as described in subrule 78.53(2).

“*Intensive residential service homes*” or “*intensive residential services*” means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation or HCBS intellectual disability waiver supported community living and meet additional criteria specified in 441—subrule 25.6(8).

“*Interdisciplinary team*” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“*ISIS*” means the department’s individualized services information system.

“*Level of Care Utilization System*” or “*LOCUS*” means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation service for individuals aged 19 and older.

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

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

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

“*Severe and persistent mental illness*” means the same as defined in rule 441—25.1(331).

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

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

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

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

a. **Age.** The member is at least 16 years of age or older.

b. **LOCUS/CALOCUS actual disposition.** The member has a LOCUS/CALOCUS actual disposition of level one recovery maintenance and health management or higher on the most current LOCUS/CALOCUS assessment completed within the past 30 days.

c. **Risk factors.** The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., crisis response services, subacute mental health services, emergency services,
alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member’s life; or

(2) The member is currently receiving habilitation or integrated health home services; or

(3) The member has a history of severe and persistent mental illness resulting in at least one episode of continuous, professional supportive care other than hospitalization (e.g., counseling, therapy, assertive community treatment, or medication management); or

(4) The member has a history of severe and persistent mental illness resulting in involvement in the criminal justice system (e.g., prior incarceration, parole, probation, criminal charges, jail diversion program or mental health court); or

(5) Traditional mental health services available in the member’s community have not been able to meet the member’s needs.

d. Need for assistance. The member has a need for assistance or is likely to need assistance related to functional impairment arising out of a mental health diagnosis typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least 12 months:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history, and the member is currently receiving employment services or the member has a need for employment services to obtain or maintain employment.

(2) The member requires financial assistance to reside independently in the community or may be homeless or at risk of homelessness if unable to procure this assistance without help.

(3) The member shows significant inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits social behavior that puts the member’s safety or others’ safety at risk, which results in the need for service intervention which may include crisis management or protective oversight.

e. Income. The countable income used in determining the member’s Medicaid eligibility does not exceed 150 percent of the federal poverty level.

f. Needs assessment. The LOCUS or CALOCUS tool has been completed in the LOCUS online system, and using the algorithm developed by Deerfield Solutions to derive the actual disposition score based on the comprehensive assessment and social history (CASH) completed by the integrated health home (IHH) or community-based case manager (CBCM) during a face-to-face interview with the member and the member’s representative as applicable, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The LOCUS/CALOCUS information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual’s case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the LOCUS or CALOCUS, before services begin and annually thereafter, and more frequently if significant observable changes occur in the member’s situation, condition or circumstances.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4) and 441—paragraph 90.4(1) “b” before services begin and annually thereafter, and when there is a significant observable change in the member’s situation, condition, or circumstances.

g. Plan for service. The department or the member’s managed care organization has approved the member’s comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated by the IME or the member’s managed care organization shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member’s eligibility for the program cannot be reimbursed.
(1) The member’s comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4) and 441—paragraph 90.4(1) “b.” A service plan may change when requested by the member or the member’s interdisciplinary team when there is a significant observable change in the member’s situation, condition, or circumstances.

(2) For members receiving home-based habilitation, the service plan shall include the member’s LOCUS/CALOCUS actual disposition, the LOCUS/CALOCUS composite score, and each individual domain score for each of the six LOCUS/CALOCUS domains.

(3) The member’s habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(4) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

**78.27(3) Application for services.** The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

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

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

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

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

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

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

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

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

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

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

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

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

b. **Service goals and activities.** The comprehensive service plan shall:
(1) Identify observable or measurable individual goals.
(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.
(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.
(4) List all Medicaid and non-Medicaid services received by the member and identify:
   1. The name of the provider responsible for delivering the service;
   2. The funding source for the service; and
   3. The number of units of service to be received by the member.
(5) Identify for a member receiving home-based habilitation:
   1. The member’s living environment at the time of enrollment;
   2. The number of hours per day of on-site staff supervision needed by the member; and
   3. The number of other members who will live with the member in the living unit.
(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.
   c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:
      (1) Any restrictions on the member’s rights, including maintenance of personal funds and self-administration of medications;
      (2) The need for the restriction; and
      (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
   d. Emergency plan. The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:
      (1) The member’s interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.
      (2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member’s needs change.
      (3) Providers of applicable services shall provide for emergency backup staff.
   e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2) “g.”

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:
   a. The services shall be based on the member’s needs as identified in the member’s comprehensive service plan.
   b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.
   c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member’s life goals.
   d. Service components that are the same or similar shall not be provided simultaneously.
   e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.
   f. Reimbursement is not available for room and board.
   g. Services shall be billed in whole units.
   h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).
78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Exclusions.

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

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

78.27(7) Home-based habilitation. “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living, working, and recreating in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member’s home and community that assist the member to reside in the most integrated setting appropriate to the member’s needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member’s comprehensive service plan. Covered supports include:

   (1) Adaptive skill development;
   (2) Assistance with activities to address daily living needs;
   (3) Assistance with symptom management and participation in mental health treatment;
   (4) Assistance with accessing physical and mental health care treatment, communication, and implementation of health care recommendations and treatment;
   (5) Assistance with accessing and participating in substance use disorder treatment and services;
   (6) Assistance with medication administration and medication management;
   (7) Assistance with understanding communication whether verbal or written;
   (8) Community inclusion and active participation in the community;
   (9) Transportation;
   (10) Adult educational supports, which may include assistance and support with enrolling in educational opportunities and participation in education and training;
   (11) Social and leisure skill development;
   (12) Personal care; and
   (13) Protective oversight and supervision.

b. Setting requirements. Home-based habilitation services shall occur in the member’s home and community.

   (1) A member may live in the member’s own home, within the home of the member’s family or legal representative, or in another community living arrangement that meets the criteria in 441—subrule 77.25(5).

   (2) A member living with the member’s family or legal representative is not subject to the criteria in 441—paragraphs 77.25(8)“e” and “d.”

   (3) A member may not reside in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

   c. Home-based habilitation level of service criteria. Home-based habilitation services shall be available to members based on the member’s most current LOCUS/CALOCUS actual disposition score, according to the following criteria:

   (1) Intensive IV residential habilitation services. Intensive IV services are provided 24 hours per day. To be eligible for intensive IV services, a member must meet the following criteria:

      1. The member has a LOCUS/CALOCUS actual disposition of level six medically managed residential services, and
      2. The member meets the criteria in 441—subparagraph 25.6(8)“e”(3).
(2) Intensive III services are provided 17 to 24 hours per day. To be eligible for intensive III services, the member must have a LOCUS/CALOCUS actual disposition of level five.

(3) Intensive II services are provided 13 to 16.75 hours per day. To be eligible for intensive II services, the member must have a LOCUS/CALOCUS actual disposition of level four.

(4) Intensive I services are provided 9 to 12.75 hours per day. To be eligible for intensive I services, the member must have a LOCUS/CALOCUS actual disposition of level three.

(5) Medium need services are provided 4.25 to 8.75 hours per day as needed. To be eligible for medium need services, the member must have a LOCUS/CALOCUS actual disposition of level two.

(6) Recovery transitional services are provided 2.25 to 4 hours per day as needed. To be eligible for recovery transitional services, the member must have a LOCUS/CALOCUS actual disposition of level one.

(7) High recovery services are provided 0.25 to 2 hours per day as needed. To be eligible for high recovery services, the member must have a LOCUS/CALOCUS actual disposition of level one.

d. Additional criteria for receiving home-based habilitation services for transition-age youth 16 to 17.5 years of age.

(1) Members residing in the family home may receive home-based habilitation services as needed, subject to the criteria set forth in this rule.

(2) Members residing outside the family home may only receive home-based habilitation services in residential settings with 16 or fewer beds licensed by the department of inspections and appeals.

(3) The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.25(5).

(4) Individuals 16 to 18 years of age shall receive 24-hour site supervision and support.

e. Additional criteria for receiving home-based habilitation services for transition-age youth 17.5 to 18 years of age.

(1) Members residing in the family home may receive home-based habilitation services as needed, subject to the criteria set forth in this rule.

(2) Members residing outside of the family home may receive daily home-based habilitation in a provider-owned or controlled setting when the following criteria are met:

1. The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.25(5).

2. All providers of the service setting being requested must meet the following additional safety and service requirements for serving youth under the age of 18:
   - Individuals 17.5 to 18 years of age shall receive 24-hour site supervision and support.
   - Individuals under the age of 18 may not reside in settings with individuals over the age of 21.
   - The comprehensive service plan shall specifically identify educational services and supports for individuals who have not obtained a high school diploma or equivalent.
   - For individuals who have obtained a high school diploma or equivalent, the comprehensive service plan shall include supported employment, additional training, or educational supports.

3. The member’s parent or guardian has consented to home-based habilitation services.

4. The member is able to pay room and board costs (funding sources may include, but are not limited to, supplemental security income, child support, adoptions subsidy, or private funds).

5. A licensed setting, such as those approved to provide residential-based supported community living, is not available.

f. Exclusions. Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.
(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or “bundled” service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. “Day habilitation” means services that provide opportunities and support for community inclusion and build interest in and develop skills for active participation in recreation, volunteerism and integrated community employment. Day habilitation provides assistance with acquisition, retention, or improvement of socialization, community participation, and daily living skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, positive social behavior, greater independence, and personal choice. Services focus on supporting the member to participate in the community, develop social roles and relationships, and increase independence and the potential for employment. Services are designed to assist the member to attain or maintain the member’s individual goals as identified in the member’s comprehensive service plan. Services may also provide wraparound support secondary to community employment. Day habilitation activities may include:

(1) Identifying the member’s interests, preferences, skills, strengths and contributions,
(2) Identifying the conditions and supports necessary for full community inclusion and the potential for competitive integrated employment,
(3) Planning and coordination of the member’s individualized daily and weekly day habilitation schedule,
(4) Developing skills and competencies necessary to pursue competitive integrated employment,
(5) Participating in community activities related to hobbies, leisure, personal health, and wellness,
(6) Participating in community activities related to cultural, civic, and religious interests,
(7) Participating in adult learning opportunities,
(8) Participating in volunteer opportunities,
(9) Training and education in self-advocacy and self-determination to support the member’s ability to make informed choices about where to live, work, and recreate,
(10) Assistance with behavior management and self-regulation,
(11) Use of transportation and other community resources,
(12) Assistance with developing and maintaining natural relationships in the community,
(13) Assistance with identifying and using natural supports,
(14) Assistance with accessing financial literacy and benefits education,
(15) Other activities deemed necessary to assist the member with full participation in the community, developing social roles and relationships, and increasing independence and the potential for employment.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the member’s home. The unit of service is 15 minutes. The units of services payable are limited to a maximum of 40 units per month.

c. Expected outcome of service. The expected outcome of day habilitation services is active participation in the community in which the member lives, works, and recreates. Members are expected to have opportunities to interact with individuals without disabilities in the community, other than those providing direct services, to the same extent as individuals without disabilities.

d. Setting. Day habilitation shall take place in community-based, nonresidential settings separate from the member’s residence. Family training may be provided in the member’s home.

e. Duration. Day habilitation services shall be furnished as specified in the member’s comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

f. Unit of service. A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

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

h. Transportation. When transportation is provided to the day habilitation service location from the member’s home and from the day habilitation service location to the member’s home, the day habilitation provider may bill for the time spent transporting the member.

i. Exclusions. Day habilitation payment shall not be made for the following:

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

(2) Compensation to members for participating in day habilitation.

(3) Support for members volunteering in for-profit organizations and businesses.

(4) Support for members volunteering to benefit the day habilitation service provider.

78.27(9) Prevocational service habilitation. “Prevocational services” means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

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

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

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

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

2. Business tours,

3. Informational interviews,

4. Job shadows,

5. Benefits education and financial literacy,

6. Assistive technology assessment, and

7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.
   
b. Setting. Prevocational services shall take place in community-based nonresidential settings.
   
c. Concurrent services. A member’s individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).
   
d. Exclusions. Prevocational services payment shall not be made for the following:
      
(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the services under these programs shall be maintained in the service plan of each member receiving prevocational services.
   
(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
   
(3) Compensation to members for participating in prevocational services.
   
(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.
   
(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.
   
(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.
   
e. Limitations.
      
(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:
   
1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member’s current service plan; or
   
2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member’s current service plan, but the member has services documented in the member’s current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or
   
3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member’s current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member’s service plan; or
   
4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member’s request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or
   
5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or
   
6. The member is participating in career exploration activities as described in subparagraph 78.27(9)“a”(1).
   
(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business
days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9) “a”(1). This time limit can be extended as stated in paragraphs 78.27(9) “e”(1)“1” through “6.” If the criteria in paragraphs 78.27(9) “e”(1)“1” through “6” do not apply, the member will not be reauthorized to continue prevocational services.

**78.27(10)** Supported employment services.

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

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

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

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

4. Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:
   1. Benefits education.
   2. Career exploration (e.g., tours, informational interviews, job shadows).
   5. Trial work experience.
   6. Person-centered employment planning.
   7. Development of visual/traditional résumés.
   8. Job-seeking skills training and support.
   9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
  10. Job analysis (e.g., work site assessment or job accommodations evaluation).
  11. Identifying and arranging transportation.
  12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
  13. Reemployment services (if necessary due to job loss).
  14. Financial literacy and asset development.
  15. Other employment support services deemed necessary to enable the member to obtain employment.
  16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
  17. Engagement of natural supports during initial period of employment.
  18. Implementation of assistive technology solutions during initial period of employment.
  19. Transportation of the member during service hours.
  20. Initial on-the-job training to stabilization activity.
(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10)“(a)”(4), assistance to establish self-employment may include:
1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.
   b. Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.
   1. Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.
   2. Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member’s personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.
   3. Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member’s home can be considered an integrated work setting. Employment in the service provider’s organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider’s organization were the provider not being paid to provide the job coaching to the member.
   4. Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:
1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.
(5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment.
In addition to the activities listed under subparagraph 78.27(10)”b”(4), assistance to maintain self-employment may include:

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

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

c. **Small-group supported employment.** Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

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

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

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

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

*d. Individual placement and support (IPS).*

1. IPS shall include the following activities, which shall be described and documented in the member’s employment plan:
   1. Development of the career profile, including previous work experience, goals, preferences, strengths, barriers, skills, disclosure preferences, career advancement, education and plan for graduation.
2. Integration of IPS team members and the behavioral health team, including routine staffing meetings regarding IPS clients.

3. Addressing barriers to employment, which may be actual or perceived. Support may include addressing justice system involvement, a lack of work history, limited housing, child care, and transportation.

4. Rapid job search and systematic job development. CESs help members seek jobs directly, and do not provide extensive preemployment assessment and training or intermediate work experiences. The job process begins within 30 days of starting IPS services. This rapid job search is supported by CESs developing relationships with employers through multiple face-to-face meetings. CESs take time to learn about the employers’ needs and the work environment while gathering information about job opportunities that might be a good fit for individuals they are working with.

5. Disclosure counseling, to assist the member in making an informed decision on disclosure of a disability to a prospective or current employer.

6. Identification and implementation of job accommodations and assistive technology supports.

7. Ongoing benefits counseling. The member must receive information on available work incentive programs, or referral to professional benefits counselors for a personalized work incentives plan for any state or federal entitlement.

8. Time-unlimited follow-along supports. These supports are planned for early in the employment process, are personalized, and follow the member for as long as the member needs support. The focus is supporting the member in becoming as independent as possible and involving family members, co-workers, and other natural supports. These supports can be provided on or off the job site and focus on the continued acquisition and development of skills needed to maintain employment.

(2) Units of service. Reimbursement is made for each outcome achieved for the member participating in the IPS supported employment model. Outcomes are as follows:

1. Outcome #1: Completed employment plan.
2. Outcome #2: First day of successful job placement.
3. Outcome #3: 45 days successful job retention.
4. Outcome #4: 90 days successful job retention.

e. **Service requirements for all supported employment services.**

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

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

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

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

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

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

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

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.
(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed $3,167.89 per month.
(3) Individual supported employment is limited to 60 hourly units per calendar year.
(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).
(5) Small-group supported employment is limited to 160 units per week.

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

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.
(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer’s participation in a supported employment program.
(3) Subsidies or payments that are passed through to users of supported employment programs.
(4) Training that is not directly related to a member’s supported employment program.
(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.
(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.
(7) Tuition for education or vocational training.
(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.
(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) Adverse service actions.

a. Denial. Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.
(2) The service is not identified in the member’s comprehensive service plan or treatment plan.
(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.
(4) The member’s service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).
(5) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member’s income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.
(2) The service is not identified in the member’s comprehensive service plan.
(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.
(4) The member’s service needs are not being met by the services provided.
(5) The member has received care in a medical institution for 120 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 120 consecutive days, the department
will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member’s service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member’s legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility or of the LOCUS/CALOCUS actual disposition score by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0799C, IAB 5/1/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2561C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 5/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5889C, IAB 7/2/21, effective 9/3/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 5889C, IAB 9/8/21, effective 11/1/21; ARC 6122C, IAB 12/9/21, effective 3/1/22; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or predetermination review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Rescinded IAB 12/30/20, effective 3/1/21.

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5)“a.”

d. Reserved.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5)“f.”

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

g. Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5)“a.”

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2)“c”)

i. Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5)“m.”
j. Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5)“c.”

k. DME rebate agreements. Payment will be approved pursuant to the criteria at 78.10(5)“e.”

l. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5)“n.”

m. Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5)“g.”

n. Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5)“h.”

o. Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5)“i.”

p. Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5)“j.”

q. Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.

r. Customized wheelchairs, subject to the requirements of 78.10(2)“d.”

**78.28(2)** Notwithstanding the provisions of 78.28(1)“a.” under both Medicaid fee-for-service and managed care administration, at least one form of each of the following drugs for medication-assisted treatment as approved by the United States Food and Drug Administration for treatment of substance use disorder or overdose treatment will be available without prior authorization:

- Buprenorphine,
- Buprenorphine and naloxone combination,
- Methadone,
- Naltrexone, and
- Naloxone.

For the purpose of this subrule, “medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with treatment services.

**78.28(3)** Dental services. Dental services which require prior approval are as follows:

- The following periodontal services:
  1. Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4)“b.”
  2. Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4)“d.”
  3. Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4)“e.”
  4. Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4)“f.”
  5. Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4)“g.”

- The following prosthetic services:
  1. A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“b.”
  2. A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“d.”
  3. A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“c.”
  4. A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)“e.”
  5. Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)“k.”
  6. Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)“l.”
  7. A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)“m.”
  8. An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)“n.”
c. The following orthodontic services:
   (1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8) “a.”
   (2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “b.”
   (3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8) “c.”
   d. The following restorative services:
      (1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3) “d”(3).
      (2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3) “d”(4).
   e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5) “d.”
   f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9) “g.”

**78.28(4)** Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:
   a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member’s vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.
   b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.
   c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.
   d. Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.
   e. Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

**78.28(5)** Hearing aids that must be submitted for prior approval are:
   a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person’s hearing that would require a different hearing aid. (Cross reference 78.14(7) “d”(1))
   b. A hearing aid costing more than $650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7) “d”(2)):
      (1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.
      (2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise
or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(6) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross reference 441—78.3(249A))

c. Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department. The criteria are available from the IME medical services unit.

78.28(7) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the department.

78.28(8) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(9) Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

78.28(10) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

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

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child’s caregiver, in the development and implementation of the plan of treatment. These services
shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:
1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member’s household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse’s aide and which are delegated and supervised by a registered nurse under the direction of the member’s physician to a member in the member’s place of residence or outside the member’s residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member’s plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child’s caregiver, in the development and implementation of the plan of treatment.

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

b. Requirements.
1. Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician’s signature on the plan of care.
2. Private duty nursing or personal care services shall be authorized by the department or the department’s designated review agent prior to payment.
3. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department’s designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department’s designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

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

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

78.28(11) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3)“b”)

78.28(12) High-technology radiology procedures.
a. Except as provided in paragraph 78.28(12)“b,” the following radiology procedures require prior approval:
(1) Magnetic resonance imaging (MRIs);
(2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;
(3) Computed tomographic angiographs (CTAs);
(4) Positron emission tomography (PETs); and
(5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(12)“a,” prior authorization is not required when any of the following applies:
   (1) Radiology procedures are billed on a CMS 1500 claim for places of service “hospital inpatient” (POS 21) or “hospital emergency room” (POS 23), or on a UB04 claim with revenue code 45X;
   (2) The member has Medicare coverage;
   (3) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted to the department of human services.

e. When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member’s receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-5595, Outpatient Prior Authorization Request, and approved before any claim for payment is submitted.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9702B, IAB 9/7/11, effective 9/1/11; ARC 9883B, IAB 11/30/11, effective 1/4/12; ARC 0305C, IAB 9/5/12, effective 11/1/12; ARC 0863C, IAB 3/6/13, effective 5/1/13; ARC 0862C, IAB 3/6/13, effective 5/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1696C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4575C, IAB 7/31/19, effective 9/4/19; ARC 4899C, IAB 2/12/20, effective 3/18/20; see Delay note at end of chapter; ARC 5362C, IAB 12/30/20, effective 3/1/21]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner’s scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations. 
   a. An assessment and a treatment plan are required.
   b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:
   a. Services provided in a medical institution.
   b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.
   c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.
   d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.
   a. Payment shall be made only for time spent in face-to-face consultation with the member.
   b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.
78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

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

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

78.30(2) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs “g” to “m” are subject to a random sample retrospective review for medical necessity by the IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs “a” to “f” shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs “g” to “m” shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. Emergency service.
b. Outpatient surgery.
c. Laboratory, X-ray and other diagnostic services.
d. General or family medicine.
e. Follow-up or after-care specialty clinics.
f. Physical medicine and rehabilitation.
g. Alcoholism and substance abuse.
h. Eating disorders.
i. Cardiac rehabilitation.
j. Mental health.
k. Pain management.
l. Diabetic education.
m. Pulmonary rehabilitation.
n. Nutritional counseling for persons aged 20 and under.

78.31(2) Requirements for all outpatient services.

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs “d” and “f” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.
d. **Treatment modalities used.** The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. **Criteria for selection and continuing treatment of patients.** The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. **Length of program.** There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. **Monitoring of services.** The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

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

78.31(3) **Application for certification.** Hospital outpatient programs listed in subrule 78.31(1), paragraphs "g" to "m," must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) **Requirements for specific types of service.**

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient’s dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.
Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family’s history of alcoholism and other drug dependencies.

The patient’s educational level, vocational status, and job performance history.

The patient’s social support networks, including family and peer relationships.

The patient’s perception of the patient’s strengths, problem areas, and dependencies.

The patient’s leisure, recreational, or vocational interests and hobbies.

The patient’s ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient’s written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient’s perception of needs and, when appropriate and available, the family’s perception of the patient’s needs shall be documented.

The patient’s participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:
The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient’s continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient’s personal support system.

The plan is in accordance with the patient’s reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient’s written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master’s or bachelor’s degree and experience, a dietitian with a bachelor’s degree and registered dietitian’s certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient’s eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient’s social support networks, including family and peer relationships.

The patient’s educational level, vocational status, and job or school performance history, as appropriate.

The patient’s leisure, recreational, or vocational interests and hobbies.
The patient’s ability to participate with peers and programs and social activities.
Interview of family members and significant others as available with the patient’s written or verbal permission as appropriate.
Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient’s perceptions of needs and, when appropriate and available, the family’s perceptions of the patient’s needs shall be documented.

The patient’s participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment.
Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph “a,” subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.
(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac disrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician.

The following conditions are eligible for the program:

- Postmyocardial infarction (within three months postdischarge).
- Postcardiac surgery (within three months postdischarge).
- Poststreptokinase.
- Postpercutaneous transluminal angioplasty (within three months postdischarge).
- Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital’s preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

- Referral form.
- Physician’s orders.
- Laboratory reports.
- Electrocardiogram reports.
- History and physical examination.
- Angiogram report, if applicable.
- Operative report, if applicable.
- Preadmission interview.
- Exercise prescription.
- Rehabilitation plan, including participant’s goals.
- Documentation for exercise sessions and progress notes.
- Nurse’s progress reports.
Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient’s condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient’s condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient’s treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient’s condition. The treatment must at a minimum be designed to reduce or control the patient’s psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient’s level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. “Improvement” in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient’s condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility’s patient load.

The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for “mental health professionals” as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.
A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.
A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.
A determination of current and past psychiatric and psychological abnormality.
A determination of any degree of danger to self or others.
The family’s history of mental health problems.
The patient’s educational level, vocational status, and job performance history.
The patient’s social support network, including family and peer relationship.
The patient’s perception of the patient’s strengths, problem areas, and dependencies.
The patient’s leisure, recreational or vocational interests and hobbies.
The patient’s ability to participate with peers in programs and social activities.
Interview of family members and significant others, as available, with the patient’s written or verbal permission.
Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.
2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.
3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.
4. Activity therapies which are individualized and essential for the treatment of the patient’s condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient’s treatment.
5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient’s condition.
6. Partial hospitalization and day treatment services to reduce or control a person’s psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person’s level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.
Services are provided for a period for four to eight hours per day.
Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.
Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.
Services are structured with an emphasis on program variation according to individual need.
Services are provided for a period of three to five hours per day, three or four times per week.
7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall
apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

8. Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

9. Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient’s response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

10. Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient’s progress.

For services that are not specifically included in the patient’s treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient’s plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

1. Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

2. General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

3. Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

4. Admission criteria. Candidates for the program shall meet the following guidelines:
The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient’s perception of needs and, when appropriate and available, the family’s perception of the patient’s needs shall be documented.

The patient’s participation in the development of the treatment plan is sought and documented. Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient’s continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient’s personal support system.

The plan is in accordance with the patient’s reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient’s written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.
(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient’s participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge.

 g. Pulmonary rehabilitation.

 (1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

 (2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

  Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

 (3) Initial assessment. A comprehensive assessment must occur initially, including:

  A diagnostic workup which entails proper identification of the patient’s specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

  Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient’s learning skills and adjusting the program to the patient’s ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

 (4) Admission criteria. Criteria include a patient’s being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician’s order to participate anyway.

  Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

 (5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

  The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

  Patients are reassessed to determine current clinical problems, needs, and responses to treatment.

  Changes in treatment are documented.

  Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

 (6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

 (7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

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

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 6222C, IAB 3/9/22, effective 5/1/22]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

1. Members who are 18 years of age or over and have a primary diagnosis of intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children’s mental health waiver.

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

[ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—78.34(249A) HCBS health and disability waiver services. Payment will be approved for the following services to members eligible for HCBS health and disability waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.34(1) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

   c. Meal preparation: planning and preparing balanced meals.

78.34(2) Home health services. Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client’s health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.
(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency’s Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) Nursing care services. Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member’s current living situation.

a. Services provided outside the member’s home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member’s interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child’s day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.34(6) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member’s family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member’s disability or terminal condition. Counseling services may be provided to the member’s caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member’s caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
78.34(7) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7)“f” and the skilled activities listed in paragraph 78.34(7)“g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.
   (1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:
      1. Select the individual or agency that will provide the components of the attendant care services.
      2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
      3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
   4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:
   1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
   2. The legal representative may not be paid for more than 40 hours of service per week; and
   3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:
   (1) Retain accountability for actions that are delegated.
   (2) Ensure appropriate assessment, planning, implementation, and evaluation.
   (3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:
   (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.
   (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.
e. **Service units and billing.** A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. **Nonskilled services.** Covered nonskilled service activities are limited to help with the following activities:

1. Dressing.
2. Bathing, shampooing, hygiene, and grooming.
3. Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
4. Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
5. Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.
6. Housekeeping, laundry, and shopping essential to the member’s health care at home.
7. Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
8. Minor wound care.
9. Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
10. Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
11. Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
12. Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. **Skilled services.** Covered skilled service activities are limited to help with the following activities:

1. Tube feedings of members unable to eat solid foods.
2. Intravenous therapy administered by a registered nurse.
3. Parenteral injections required more than once a week.
4. Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
5. Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
6. Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
7. Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
8. Colostomy care.
9. Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
11. Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
13. Recording and reporting of changes in vital signs to the nurse or therapist.

h. **Excluded services and costs.** Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

1. Any activity related to supervising a member. Only direct services are billable.
2. Any activity that the member is able to perform.
3. Costs of food.
(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.34(8) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member’s living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member’s usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member’s social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member’s home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above
the usual and customary cost of day care services due to the member’s medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member’s home or vehicle that directly address the member’s medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member’s medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:
   (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
   (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
   (3) Grab bars and handrails.
   (4) Turnaround space adaptations.
   (5) Ramps, lifts, and door, hall and window widening.
   (6) Fire safety alarm equipment specific for disability.
   (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member’s disability.
   (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
   (9) Keyless entry systems.
   (10) Automatic opening device for home or vehicle door.
   (11) Special door and window locks.
   (12) Specialized doorknobs and handles.
   (13) Plexiglas replacement for glass windows.
   (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
   (15) Motion detectors.
   (16) Low-pile carpeting or slip-resistant flooring.
   (17) Telecommunications device for the deaf or hard of hearing.
   (19) New door opening.
   (20) Pocket doors.
   (21) Installation or relocation of controls, outlets, switches.
   (22) Air conditioning and air filtering if medically necessary.
   (23) Heightening of existing garage door opening to accommodate modified van.
   (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers’ compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle
modification provider following completion of the approved modifications. Payment of up to $6,592.66 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member’s service plan and shall exceed the Medicaid state plan services.

78.34(10) Personal emergency response or portable locator system. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:
   1. An in-home medical communications transceiver.
   2. A remote, portable activator.
   3. A central monitoring station with backup systems staffed by trained attendants at all times.
   4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.
(2) The service shall be identified in the member’s service plan.
(3) A unit of service is a one-time installation fee or one month of service.
(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member’s age or disability.

(1) The required components of the portable locator system are:
   1. A portable communications transceiver or transmitter to be worn or carried by the member.
   2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
(2) The service shall be identified in the member’s service plan.
(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member’s residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member’s service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.34(12) Nutritional counseling. Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.
78.34(13) *Consumer choices option.* The consumer choices option (CCO) provides a member with a flexible monthly individual budget that is based on the member’s service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member’s assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member’s assessed need or goal established in the member’s service plan. The consumer choices option is available to any member receiving the AIDS/HIV, brain injury, elderly, health and disability, intellectual disability, or physical disability waiver programs who has the ability and desire to perform all budget authority tasks identified in paragraph 78.34(13)“g” and employer authority tasks identified in paragraph 78.34(13)“h,” or who delegates the budget or employer authority tasks identified in paragraph 78.34(13)“i.” Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member’s service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.

(3) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(4) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.
(5) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:
   1. Consumer-directed attendant care (unskilled).
   2. Home and vehicle modification.
   3. Prevocational services.
   4. Basic individual respite care.
   5. Specialized medical equipment.
   6. Supported community living.
   7. Supported employment.
   8. Transportation.

(6) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:
   1. Consumer-directed attendant care (unskilled).
   2. Home and vehicle modification.
   3. Specialized medical equipment.
   4. Transportation.

(7) The department shall determine an average unit cost for each service listed in subparagraphs 78.34(13)“b”(1) to (6) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(8) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member’s service plan before calculating the value of that service to be included in the individual budget amount.

(9) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent.

(10) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)“b”(7). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)“b”(8).

(11) Anticipated costs for home and vehicle modification, assistive devices, and specialized medical equipment are not subject to the average cost in subparagraph 78.34(13)“b”(7) or the utilization adjustment factor in subparagraph 78.34(13)“b”(8). The anticipated costs may include the costs of the financial management services and the independent support broker when the home and vehicle modification, assistive device, or specialized medical equipment is the only service included in the CCO monthly budget and the total cost for the home and vehicle modification, assistive device, or specialized medical equipment, including the cost of the financial management services and the independent support broker, is approved by the Iowa Medicaid enterprise or managed care organization as the least costly option to meet the member’s need. Costs for the home and vehicle modification, assistive device, or specialized medical equipment may be paid to the financial management services provider in a one-time payment. Before becoming part of the CCO monthly budget, all home and vehicle modifications, assistive device, and specialized medical equipment shall be identified in the member’s service plan and authorized by the case manager or community-based case manager.

(12) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:
(1) Self-directed personal care services. Self-directed personal care services are services that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or community-based case manager.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member’s service plan developed by the member’s case manager or community-based case manager.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:
   1. Promote opportunities for community living and inclusion.
   2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
   3. Be accommodated within the member’s budget without compromising the member’s health and safety.
   4. Be provided to the member or directed exclusively toward the benefit of the member.
   5. Be the least costly to meet the member’s needs.
   6. Not be available through another source.
   e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member’s individual budget. The individual budget shall include:
      1. The costs of the financial management service.
      2. The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)“d.” At a minimum, the CCO monthly budget must include the purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services needed to meet the amount of service authorized for use in CCO identified in the member’s service plan. After funds have been budgeted to meet the identified needs, remaining funds from the monthly budget amount may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services as allowed by the monthly budget. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services may exceed the amount of service or supports authorized in the member’s service plan. Costs of the following items and services shall not be covered by the individual budget:
   1. Child care services.
   2. Clothing not related to an assessed medical need.
   3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
   4. Costs associated with shipping items to the member.
   5. Experimental and non-FDA-approved medications, therapies, or treatments.
   6. Goods or services covered by other Medicaid programs.
   8. Home repairs or home maintenance.
   9. Homeopathic treatments.
   10. Insurance premiums or copayments.
   11. Items purchased on installment payments.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member’s service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.
23. Services provided in the family home by a parent, stepparent, legal representative, sibling, or stepsibling during overnight sleeping hours unless the parent, stepparent, legal representative, sibling, or stepsibling is awake and actively providing direct services as authorized in the member’s service plan.
24. Residential services provided to three or more members living in the same residential setting.

(4) The costs of any approved home or vehicle modification, assistive device, or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification, an assistive device, or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications, assistive devices, and specialized medical equipment shall be identified in the member’s service plan and approved by the case manager or community-based case manager. The authorized amount shall not be used for anything other than the specific modification, assistive device, or specialized medical equipment, as identified in subparagraph 78.34(13) "b" '(11).

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13) “d.” The savings plan shall meet the requirements in paragraph 78.34(13) “f.”

f. Savings plan. A member savings plan must be in writing and be approved before the start of the savings plan by the department for fee-for-service members or by the member’s managed care organization for members in managed care. Budget amounts allocated to the savings plan must result from efficiencies in meeting the member’s service needs identified in the member’s service plan.

(1) The savings plan shall identify:
   1. The specific goods, services, supports or supplies to be purchased through the savings plan.
   2. The amount of the individual budget allocated each month to the savings plan.
   3. The amount of the individual budget allocated each month to meet the member’s identified service needs.
   4. How the member’s assessed needs will continue to be met through the individual budget when funds are placed in savings.
   5. Specific time spans for accumulating the savings allocation, not to exceed the member’s current service plan year end date.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services or supports that were not received. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds allocated to a savings plan may be used to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services. The additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services included in the monthly budget may exceed the amount of service or supports authorized in the member’s service plan. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:
   1. Be used to meet a member’s identified need,
   2. Be medically necessary, and
3. Be approved by the member’s case manager or community-based case manager.

(4) All funds allocated to a savings plan to purchase additional self-directed personal care, individual-directed goods and services, or self-directed community supports and services must be used during the member’s waiver year in which the saving occurred.

(5) The annual reassessment of a member’s needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

(g) **Budget authority.** The member shall have authority over the individual budget authorized by the department or managed care organization to perform the following tasks:

1. Contract with entities to provide services and supports as described in this subrule.
2. Determine the amount to be paid for services. Reimbursement rates for employees shall be consistent with employee reimbursement rates or the prevailing wages paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).
3. Schedule the provision of services. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the member’s employee is unable to provide services due to illness or other unexpected event.
4. Authorize payment for optional service components identified in the individual budget. When the member’s guardian or legal representative is a paid employee, payment authorization for optional service components must be delegated to a representative pursuant to paragraph 78.34(13)“i.”
5. Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

(h) **Employer authority.** The member shall have the authority to be the common-law employer of employees providing services and support under the CCO. A common-law employer has the right to direct and control the performance of the services. If the member is a child, the parent or the legal representative shall be responsible for completing all employer authority tasks. Adult members who do not have the ability to complete all employer authority tasks shall have a representative delegated to complete the employer authority tasks identified in this paragraph. Documentation of the person responsible for the employer authority tasks, whether the member or another entity, shall be included in the member’s service plan. The member or the delegated employer authority may perform the following functions:

1. Recruit and hire employees.
2. Verify employee qualifications.
3. Specify additional employee qualifications.
4. Determine employee duties.
5. Determine employee wages and benefits.
7. Train and supervise employees.

(i) **Delegation of budget and employer authority.** The member may delegate responsibilities for the individual budget or employer authority functions to a representative. If the member is a child, the parent or the legal representative shall be delegated all budget and employer authority tasks. Adult members aged 18 and older who do not have the ability to complete all budget or employer authority tasks shall have a representative delegated to complete the applicable budget authority tasks identified in paragraph 78.34(13)”g” and employer authority tasks identified in paragraph 78.34(13)”h.” Documentation of the person responsible for the budget and employer authority tasks, whether the member or a representative, shall be included in the member’s service plan.

1. The representative must be at least 18 years old.
2. The representative shall not be a current provider of service to the member.
3. The member shall sign a consent form that designates who the member has chosen as a representative and the responsibilities of the representative.
4. The representative shall not be paid for this service.
j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee’s and member’s responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member’s representative:

1. Assist the member with developing the member’s initial and subsequent individual budgets and with making any changes to the individual budget.
2. Have monthly contact with the member for the first four months of implementation of the initial individual budget and have, at a minimum, quarterly contact thereafter.
3. Complete the required employment packet with the financial management service.
4. Assist with interviewing potential employees and entities providing services and supports if requested by the member.
5. Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
6. Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
7. Assist the member with negotiating with entities providing services and supports if requested by the member.
8. Assist the member with contracts and payment methods for services and supports if requested by the member.
9. Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
10. Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
11. Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member’s individual budget has addressed the member’s needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

1. Receive Medicaid funds in an electronic transfer.
2. Process and pay invoices for approved goods and services included in the individual budget.
3. Monitor and track the approved individual budget amount authorized each month and document all expenditures as they are paid.
4. Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
5. Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
6. Verify for the member an employee’s citizenship or alien status.
7. Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
   1. Verifying that hourly wages comply with federal and state labor rules.
   2. Collecting and processing timecards.
   3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee’s pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
(8) Assist the member in completing required federal, state, and local tax and insurance forms.
(9) Establish and manage documents and files for the member and the member’s employees.
(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
(13) Establish a customer services complaint reporting system.
(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
(15) Develop a business continuity plan in the case of emergencies and natural disasters.
(16) Provide to the department an annual independent audit of the financial management service.
(17) Assist in implementing the state’s quality management strategy related to the financial management service.
(18) The department may request that the financial management service provider withhold payment to any member or member’s employee to offset any overpayment or enforce any sanction placed on the service provider pursuant to rule 441—79.3(249A).

m. Responsibilities of the member and the employee. A member participating in the CCO and the member’s employee(s) are responsible for the following:
(1) A member participating in the CCO shall be jointly and severally liable with any of the member’s employees for any overpayment of medical assistance funds used through a CCO budget.
(2) A member may not employ any person who has been sanctioned, or who is affiliated with a person or an entity that has been sanctioned, under 441—Chapter 79. For purposes of this subparagraph, “sanction” also includes anyone who has been temporarily suspended for a credible allegation of fraud under 42 CFR Part 455. Any CCO funds paid to any employee who or which has been sanctioned is an overpayment that the department shall recoup under 441—Chapter 79.
(3) A member may not employ any person who has been excluded by the Office of the Inspector General of the Department of Health and Human Services under Sections 1128 or 1156 of the Social Security Act and is not eligible to receive federal funds.
(4) For personal care services, employees shall use an electronic visit verification system that captures all documentation requirements of the Consumer Choices Option Semi-Monthly Time Sheet (Form 470-4429) or use Form 470-4429. All other employees shall complete, sign and date Form 470-4429, Consumer Choices Option Semi-Monthly Time Sheet, for each date of service provided to a member. All employees shall maintain documentation that complies with rule 441—79.3(249A).
(5) Members shall sign, and certify under penalty of perjury, each employee timecard identified in subparagraph 78.34(13)“m”(4) prior to the timecard’s submission to the financial management service provider for payment in order to verify that all information on the submitted timecard accurately describes the amount, duration, and scope of services provided. When timecard information is submitted to the financial management service provider in an electronic format, the member shall retain the signed employee timecard for five years from the date of service.

78.34(14) General service standards. All health and disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member’s service plan.

c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
(1) Any restrictions on the member’s rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
(2) The need for the restriction.
(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

1. Add together the minutes spent on all billable activities during a calendar day for a daily total.

2. For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

3. Round the remainder using these guidelines: Round 1 to 7 minutes down to zero minutes; round 8 to 14 minutes up to one unit.

4. Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9984B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0790C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1670C, IAB 9/3/14, effective 8/13/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4439C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5806C, IAB 7/28/21, effective 9/1/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual’s family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

1. Nursing care.
2. Medical social services.
3. Physician services.
4. Counseling services provided to the terminally ill individual and the individual’s family members or other persons caring for the individual at the individual’s place of residence, including bereavement, dietary, and spiritual counseling.
5. Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.
6. Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual’s terminal illness and related conditions, except for “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.
(7) Homemaker and home health aide services.
(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.
(9) Other items or services specified in the resident’s plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual’s death to the individual’s family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) Categories of care. Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) Residence in a nursing facility. For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident’s personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident’s hospice care and the facility agrees to provide room and board to the resident.

78.36(4) Approval for hospice benefits. Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their
life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. **Physician certification process.** The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

1. The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual’s attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient’s record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual’s medical prognosis is that the individual’s life expectancy is six months or less if the illness runs its normal course.

2. When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual’s attending physician (if the individual has an attending physician). The certification must include the statement that the individual’s medical prognosis is that the individual’s life expectancy is six months or less, if the illness runs its normal course.

3. Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. **Election procedures.** Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

1. **Election statement.** An individual, or individual’s representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, or a Medicare election of hospice benefit form, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:
   1. Identification of the hospice that will provide the care.
   2. Acknowledgment that the recipient has been given a full understanding of hospice care.
   3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
   4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
   5. The recipient’s Medicaid number.
   6. The effective date of election.
   7. The recipient’s signature.

2. **Change of designation.** An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

3. **Effective date.** An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

4. **Duration of election.** The election to receive hospice care will be considered to continue until one of the following occurs:
   1. The individual dies.
   2. The individual or the individual’s representative revokes the election.
   3. The individual’s situation changes so that the individual no longer qualifies for the hospice benefit.
   4. The hospice elects to terminate the recipient’s enrollment in accordance with the hospice’s established discharge policy.

5. **Revocation.** Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual’s representative revokes the hospice benefit allowed under Medicaid. When
an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

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

[ARC 3553C, IAB 1/3/18, effective 2/7/18]

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.37(1) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

   (1) The necessary components of a system are:
   1. An in-home medical communications transceiver.
   2. A remote, portable activator.
   3. A central monitoring station with backup systems staffed by trained attendants at all times.
   4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

   (2) The service shall be identified in the member’s service plan.

   (3) A unit of service is a one-time installation fee or one month of service.

   (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member’s age or disability.

   (1) The required components of the portable locator system are:
   1. A portable communications transceiver or transmitter to be worn or carried by the member.
   2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

   (2) The service shall be identified in the member’s service plan.

   (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

   (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.
e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client’s health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.37(5) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient’s condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member’s current living situation.

a. Services provided outside the member’s home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member’s interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.37(7) Chore services. Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7) “a. ” as necessary to allow a member to remain in the member’s own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;

2) Minor repairs to walls, floors, stairs, railings and handles;
(3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;

(4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member’s residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member’s service plan.

d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals exceed the number of authorized days in a month. Meals billed in excess of the calendar days in a calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.37(9) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member’s home or vehicle that directly address the member’s medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member’s medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member’s disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.
(17) Telecommunications device for the deaf or hard of hearing.
(19) New door opening.
(20) Pocket doors.
(21) Installation or relocation of controls, outlets, switches.
(22) Air conditioning and air filtering if medically necessary.
(23) Heightening of existing garage door opening to accommodate modified van.
(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers’ compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member’s service plan and shall exceed the Medicaid state plan services.

78.37(10) Mental health outreach. Mental health outreach services are services provided in a recipient’s home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer’s interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) Nutritional counseling. Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) Assistive devices. Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member’s service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) Senior companion. Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)”f” and the skilled activities listed in paragraph 78.37(15)”g.” Covered service activities must be essential to the health, safety, and welfare
of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.
   1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.
   2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
   3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
   4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:
   1. Retain accountability for actions that are delegated.
   2. Ensure appropriate assessment, planning, implementation, and evaluation.
   3. Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:
   1. The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.
   2. The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.
f. **Nonskilled services.** Covered nonskilled service activities are limited to help with the following activities:

1. Dressing.
2. Bathing, shampooing, hygiene, and grooming.
3. Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
4. Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
5. Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.
6. Housekeeping, laundry, and shopping essential to the member’s health care at home.
7. Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
8. Minor wound care.
9. Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
10. Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
11. Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
12. Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

**g. Skilled services.** Covered skilled service activities are limited to help with the following activities:

1. Tube feedings of members unable to eat solid foods.
2. Intravenous therapy administered by a registered nurse.
3. Parenteral injections required more than once a week.
4. Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
5. Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
6. Care of decubitis and other ulcerated areas, noting and reporting to the nurse or therapist.
7. Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
8. Colostomy care.
9. Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
11. Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
13. Recording and reporting of changes in vital signs to the nurse or therapist.

**h. Excluded services and costs.** Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

1. Any activity related to supervising a member. Only direct services are billable.
2. Any activity that the member is able to perform.
3. Costs of food.
4. Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may
be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.37(16) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.37(17) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) Assisted living service. The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

a. A unit of service is one day.

b. A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day’s bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member’s response to the service. The documented assisted living service cannot also be an authorized CDAC service.

78.37(19) General service standards. All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member’s service plan.

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

(1) Any restrictions on the member’s rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.
(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:
   (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
   (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
   (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
   (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0790C, IAB 5/1/13, effective 7/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/9/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2340C, IAB 1/6/16, effective 2/10/16; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 5/18/20; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member’s family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member’s disability or terminal condition. Counseling services may be provided to the member’s caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member’s caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

a. Observation and reporting of physical or emotional needs.
b. Helping a client with bath, shampoo, or oral hygiene.
c. Helping a client with toileting.
d. Helping a client in and out of bed and with ambulation.
e. Helping a client reestablish activities of daily living.
f. Assisting with oral medications ordinarily self-administered and ordered by a physician.
g. Performing incidental household services which are essential to the client’s health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.
78.38(3) Homemaker services. Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:
   a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
   b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.
   c. Meal preparation: planning and preparing balanced meals.

78.38(4) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.
   a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.
   b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.
   c. A unit of service is 15 minutes.
   d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.
   e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.
   f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.
   g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.
   h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

78.38(6) Home-delivered meals. Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.
   a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.
   b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.
   c. A unit of service is a meal (morning, noon, evening, or liquid supplement). Any maximum combination of any two meals (morning, noon, evening, or liquid supplement) is allowed per day. Duplication of a meal in any one day is not allowed. The number of approved meals (morning, noon, evening, or liquid supplement) is contained in the member's service plan.
   d. The number of meals delivered for any morning, noon, evening, or liquid supplement meal cannot exceed the number of calendar days in a calendar month; nor can the number of delivered meals
 exceed the number of authorized days in a month. Meals billed in excess of the calendar month and those billed in excess of the number of authorized days in a month are subject to recoupment or denial of payment.

78.38(7) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8) “f” and the skilled activities listed in paragraph 78.38(8) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.
(2) Ensure appropriate assessment, planning, implementation, and evaluation.
(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.
d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

1. The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

2. The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

1. Dressing.
2. Bathing, shampooing, hygiene, and grooming.
3. Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
4. Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
5. Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.
6. Housekeeping, laundry, and shopping essential to the member’s health care at home.
7. Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
8. Minor wound care.
9. Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
10. Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
11. Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
12. Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

1. Tube feedings of members unable to eat solid foods.
2. Intravenous therapy administered by a registered nurse.
3. Parenteral injections required more than once a week.
4. Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
5. Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
6. Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
7. Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
8. Colostomy care.
9. Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.
(2) Any activity that the member is able to perform.
(3) Costs of food.
(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
(5) Exercise that does not require skilled services.
(6) Parenting or child care for or on behalf of the member.
(7) Reminders and cueing.
(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
(9) Transportation costs.
(10) Wait times for any activity.

78.38(9) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.38(10) General service standards. All AIDS/HIV waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member’s service plan.

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

(1) Any restrictions on the member’s rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
(2) The need for the restriction.
(3) The less intrusive methods of meeting the need that have been tried but did not work.
(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
(6) The informed consent of the member.
(7) An assurance that the interventions and supports will cause no harm to the member.
(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 3552C, IAB 1/3/18, effective 2/7/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5597C, IAB 5/5/21, effective 7/1/21]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

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

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

78.39(3) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccines. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.
441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member’s home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

1. Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

2. Individual advocacy is the act or process of representing the member’s rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member’s needs.

3. Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

   1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member’s personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

   2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

   3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

4. Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

5. Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life’s activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

6. Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member’s functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human
Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member’s functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member’s family or legal representative or in another typical community living arrangement.

(2) A member living with the member’s family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member’s family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect costs associated with members’ specific support needs as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager’s service plan, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member’s service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1) ‘f’(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496

15-minute units are available.

h. The service shall be identified in the member’s service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member’s current living situation.

a. Services provided outside the member’s home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member’s interdisciplinary team.
c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child’s day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite services shall not be simultaneously reimbursed with other residential, supported community living, nursing, or home health aide services provided through the medical assistance program.

i. Payment for respite services shall not exceed $7,595 per the member’s waiver year.

78.41(3) Personal emergency response or portable locator system.

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:
1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member’s service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member’s age or disability.

(1) The required components of the portable locator system are:
1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member’s service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member’s home or vehicle that directly address the member’s medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member’s medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member’s disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf or hard of hearing.


(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers’ compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member’s service plan and shall exceed the Medicaid state plan services.

78.41(5) Nursing services. Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer’s individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) Home health aide services. Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member’s service plan.

b. A unit is one hour.
c. A maximum of 14 units are available per week.

78.41(7) **Supported employment services.** Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) **Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8)(f) and the skilled activities listed in paragraph 78.41(8)(g). Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. **Service planning.**

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)“b,” the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. **Supervision of skilled services.** Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

1. Retain accountability for actions that are delegated.
2. Ensure appropriate assessment, planning, implementation, and evaluation.
3. Make on-site supervisory visits every two weeks with the service provider present.

c. **Service documentation.** The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. **Role of guardian or attorney.** If the member has a guardian or attorney in fact under a durable power of attorney for health care:

1. The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.
(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

   (1) Dressing.
   (2) Bathing, shampooing, hygiene, and grooming.
   (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
   (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
   (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.
   (6) Housekeeping, laundry, and shopping essential to the member’s health care at home.
   (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.
   (8) Minor wound care.
   (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
   (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.
   (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.
   (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

   (1) Tube feedings of members unable to eat solid foods.
   (2) Intravenous therapy administered by a registered nurse.
   (3) Parenteral injections required more than once a week.
   (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
   (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
   (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
   (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.
   (8) Colostomy care.
   (9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
   (10) Postsurgical nursing care.
   (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
   (12) Preparing and monitoring response to therapeutic diets.
   (13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

   (1) Any activity related to supervising a member. Only direct services are billable.
(2) Any activity that the member is able to perform.
(3) Costs of food.
(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
(5) Exercise that does not require skilled services.
(6) Parenting or child care for or on behalf of the member.
(7) Reminders and cueing.
(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
(9) Transportation costs.
(10) Wait times for any activity.

**78.41(9) Interim medical monitoring and treatment services.** Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member’s living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member’s usual caregivers to be employed,
(2) During a search for employment by a usual caregiver,
(3) To allow for academic or vocational training of a usual caregiver,
(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member’s social, emotional, intellectual, and physical development;
(2) Include comprehensive developmental care and any special services for a member with special needs; and
(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.
(2) Covered services do not include a complete nutritional regimen.
(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
(4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member’s home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
(5) The member-to-staff ratio shall not be more than six members to one staff person.
(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical
care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member’s medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) Residential-based supported community living services. Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child’s ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child’s communication and socialization skills, including interventions to develop a child’s ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child’s family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child’s family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child’s stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child’s service plan pursuant to 441—paragraph 77.37(23)“d.”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed when HCBS intellectual disability waiver daily supported community living service is authorized in a member’s service plan.

78.41(12) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), or a full day (4.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.
78.41(13) **Prevocational services.** Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) **Day habilitation.** Day habilitation services will be provided pursuant to subrule 78.27(8).

78.41(15) **Consumer choices option.** The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.41(16) **General service standards.** All intellectual disability waiver services must be provided in accordance with the following standards:

- a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

- b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member’s service plan.

- c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
  
  1. Any restrictions on the member’s rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

  2. The need for the restriction.

  3. The less intrusive methods of meeting the need that have been tried but did not work.

  4. Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

  5. Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

  6. The informed consent of the member.

  7. An assurance that the interventions and supports will cause no harm to the member.

  8. A regular collection and review of data to measure the ongoing effectiveness of the restriction.

  d. Services must be billed in whole units.

- e. For all services with a 15-minute unit of service, the following rounding process will apply:
  
  1. Add together the minutes spent on all billable activities during a calendar day for a daily total.

  2. For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

  3. Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

  4. Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 1/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2059C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/3/18; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5307C, IAB 12/2/20, effective 2/1/21; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22]

441—78.42(249A) **Pharmacists providing covered vaccines.** When the authorized pharmacist providing the vaccine meets all Iowa board of pharmacy expanded practice standards and Medicaid requirements, payment will be made for the following:

78.42(1) **Vaccines administered to children.** Payment will be made to an enrolled provider for an administration fee for vaccines available through the Vaccines for Children (VFC) program administered by the department of public health if the provider is enrolled in the VFC program. Payment will be made for the vaccine cost only if the VFC program stock has been depleted.

78.42(2) **Vaccines administered to adults.** Payment will be made to an enrolled provider for an administration fee and vaccine cost.
**78.42(3)** Verification and reporting. Prior to the ordering and administration of an immunization pursuant to statewide protocol, the authorized pharmacist shall consult and review the Iowa Immunization Registry Information System (IRIS) or Iowa Health Information Network (IHIN). Within 30 calendar days following administration of any vaccine, the pharmacist shall report such administration to the patient’s primary health care provider, primary physician, and IRIS or IHIN. If a patient does not have a primary health care provider, the pharmacist shall provide the patient with a written record of the vaccine administered to the patient and shall advise the patient to consult a physician.

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

[ARC 5175C, IAB 9/9/20, effective 6/1/21]

**441—78.43(249A) HCBS brain injury waiver services.** Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

**78.43(1)** Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

**78.43(2)** Supported community living services. Supported community living services are provided by the provider within the member’s home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member’s rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member’s needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member’s personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and
prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

4. Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

5. Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life’s activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

6. Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member’s functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimen designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member’s functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

1. Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

2. Supported community living services shall be available at a 15-minute rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

1. A member may live in the home of the member’s family or legal representative or in another typical community living arrangement.

2. A member living with the member’s family or legal representative is not subject to the maximum of four residents in a living unit.

3. A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member’s family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members’ specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager’s service plan, the total costs
shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member’s service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2) “e”(1) does not apply.

  f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.
(2) 33,580 15-minute units per state fiscal year except a leap year, when 33,672 15-minute units are available.

  g. The service shall be identified in the member’s service plan.

  h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member’s current living situation.

  a. Services provided outside the member’s home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

  b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member’s interdisciplinary team.

  c. A unit of service is 15 minutes.

  d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child’s day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

  e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

  f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

  g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

  h. Respite services shall not be provided simultaneously with other residential, supported community living services, nursing, or home health aide services provided through the medical assistance program.

78.43(4) Supported employment services. Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member’s home or vehicle that directly address the member’s medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

  a. Modifications that are necessary or desirable without regard to the member’s medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

  b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
(3) Grab bars and handrails.
(4) Turnaround space adaptations.
(5) Ramps, lifts, and door, hall and window widening.
(6) Fire safety alarm equipment specific for disability.
(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member’s disability.
(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
(9) Keyless entry systems.
(10) Automatic opening device for home or vehicle door.
(11) Special door and window locks.
(12) Specialized doorknobs and handles.
(13) Plexiglas replacement for glass windows.
(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
(15) Motion detectors.
(16) Low-pile carpeting or slip-resistant flooring.
(17) Telecommunications device for the deaf or hard of hearing.
(19) New door opening.
(20) Pocket doors.
(21) Installation or relocation of controls, outlets, switches.
(22) Air conditioning and air filtering if medically necessary.
(23) Heightening of existing garage door opening to accommodate modified van.
(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers’ compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to $6,592.66 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member’s service plan and shall exceed the Medicaid state plan services.

**78.43(6) Personal emergency response or portable locator system.**

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:
1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member’s service plan.
(3) A unit is a one-time installation fee or one month of service.
(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law
enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member’s age or disability.

(1) The required components of the portable locator system are:
   1. A portable communications transceiver or transmitter to be worn or carried by the member.
   2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member’s service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) Specialized medical equipment.
   a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:
      (1) Provide for health and safety of the member,
      (2) Are not ordinarily covered by Medicaid,
      (3) Are not funded by educational or vocational rehabilitation programs, and
      (4) Are not provided by voluntary means.
   b. Coverage includes, but is not limited to:
      (1) Electronic aids and organizers.
      (2) Medicine dispensing devices.
      (3) Communication devices.
      (4) Bath aids.
      (5) Noncovered environmental control units.
      (6) Repair and maintenance of items purchased through the waiver.
   c. Payment of up to $6,592.66 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.
   d. The need for specialized medical equipment shall be:
      (1) Documented by a health care professional as necessary for the member’s health and safety, and
      (2) Identified in the member’s service plan.
   e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) Family counseling and training services. Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer’s or family members’ capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer’s family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.
Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) **Prevocational services.** Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) **Behavioral programming.** Behavioral programming consists of individually designed strategies to increase the consumer’s appropriate behaviors and decrease the consumer’s maladaptive behaviors which have interfered with the consumer’s ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.
b. Development of a structured behavioral intervention plan which should be identified in the ITP.
c. Implementation of the behavioral intervention plan.
d. Ongoing training and supervision to caregivers and behavioral aides.
e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) **Consumer-directed attendant care service.** Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13)’f’’ and the skilled activities listed in paragraph 78.43(13)’g.’ Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. **Service planning.**

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.
2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)’b,’ the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
2. The legal representative may not be paid for more than 40 hours of service per week; and
3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. **Supervision of skilled services.** Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.
(2) Ensure appropriate assessment, planning, implementation, and evaluation.
(3) Make on-site supervisory visits every two weeks with the service provider present.
c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

   (1) The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

   (2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

   (1) Dressing.

   (2) Bathing, shampooing, hygiene, and grooming.

   (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

   (4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

   (5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.

   (6) Housekeeping, laundry, and shopping essential to the member’s health care at home.

   (7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

   (8) Minor wound care.

   (9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

   (10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

   (11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

   (12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

   (1) Tube feedings of members unable to eat solid foods.

   (2) Intravenous therapy administered by a registered nurse.

   (3) Parenteral injections required more than once a week.

   (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

   (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

   (6) Care of decubitis and other ulcerated areas, noting and reporting to the nurse or therapist.

   (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing
programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.
(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.
(10) Postsurgical nursing care.
(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
(12) Preparing and monitoring response to therapeutic diets.
(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):
(1) Any activity related to supervising a member. Only direct services are billable.
(2) Any activity that the member is able to perform.
(3) Costs of food.
(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.
(5) Exercise that does not require skilled services.
(6) Parenting or child care for or on behalf of the member.
(7) Reminders and cueing.
(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
(9) Transportation costs.
(10) Wait times for any activity.

78.43(14) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults aged 18 to 20 whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member’s living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:
(1) To allow the member’s usual caregivers to be employed,
(2) During a search for employment by a usual caregiver,
(3) To allow for academic or vocational training of a usual caregiver,
(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:
(1) Provide experiences for each member’s social, emotional, intellectual, and physical development;
(2) Include comprehensive developmental care and any special services for a member with special needs; and
(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.
c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.
d. Limitations.
   (1) A maximum of 12 hours of service is available per day.
   (2) Covered services do not include a complete nutritional regimen.
   (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
   (4) Interim medical monitoring and treatment services shall be provided in the following settings that are approved by the department as integrated, community-based settings: the member’s home; a registered child development home; a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
   (5) The member-to-staff ratio shall not be more than six members to one staff person.
   (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member’s medical condition, the costs above the usual and customary cost shall be covered as IMMT services.
e. A unit of service is 15 minutes.

78.43(15) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.43(16) General service standards. All brain injury waiver services must be provided in accordance with the following standards:
   a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
   b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member’s service plan.
   c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
      (1) Any restrictions on the member’s rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
      (2) The need for the restriction.
      (3) The less intrusive methods of meeting the need that have been tried but did not work.
      (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
      (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
   d. Services must be billed in whole units.
   e. For all services with a 15-minute unit of service, the following rounding process will apply:
      (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
      (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
      (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member’s home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.
b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:
   (1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;
   (2) The member’s judgment, impulse control, or cognitive perceptual abilities are compromised; and
   (3) The member exhibits significant impairment in social, interpersonal, or familial functioning.
c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:
   (1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or
   (2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.
e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member’s functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:
   (1) Is medically stable;
   (2) Does not require a level of care that includes more intensive medical monitoring;
   (3) Presents a low risk to self, others, or property, with treatment and support; and
   (4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:
   (1) Treatment objectives and outcomes,
   (2) The expected frequency and duration of each service,
   (3) The location where the services will be provided,
   (4) A crisis plan, and
   (5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

   a. Evaluation and medication management.
      (1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.
      (2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member’s complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member’s complaints and symptoms.

   b. Integrated therapy and counseling for mental health and substance abuse. This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

   c. Skill teaching. Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

   d. Community support. Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:
      (1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.
      (2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

   e. Medication monitoring. Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:
      (1) Monitoring the member’s day-to-day functioning, medication compliance, and access to medications; and
      (2) Ensuring that the member keeps appointments.
f. Case management for treatment and service plan coordination. Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member’s medical symptoms and remedial functional impairments.

   (1) Case management includes:
   1. Assessments, referrals, follow-up, and monitoring.
   2. Assisting the member in gaining access to necessary medical, social, educational, and other services.
   3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

   (2) The team shall:
   1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.
   2. Make referrals to services and related activities to assist the member with the assessed needs.
   3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.
   4. Hold daily team meetings to facilitate ACT services and coordinate the member’s care with other members of the team.

   (3) Crisis response. Crisis response consists of direct assessment and treatment of the member’s urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

   (4) Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

      (1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.
      (2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.
      (3) Providing supports to maintain employment, such as crisis intervention related to employment.
      (4) Teaching communication, problem solving, and safety skills.
      (5) Teaching personal skills such as time management and appropriate grooming for employment.

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

   [ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 1859C, IAB 2/4/15, effective 4/1/15; ARC 2164C, IAB 9/30/15, effective 10/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

   78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1) “f” and the skilled activities listed in paragraph 78.46(1) “g.” Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

      a. Service planning.
1. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:
   1. Select the individual or agency that will provide the components of the attendant care services.
   2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.
   3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.
   4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member’s service plan and shall be kept in the member’s records, in the provider’s records, and in the service worker’s or case manager’s records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7) “b,” the following shall apply:
   1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;
   2. The legal representative may not be paid for more than 40 hours of service per week; and
   3. A contingency plan must be established in the member’s service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:
   1. Retain accountability for actions that are delegated.
   2. Ensure appropriate assessment, planning, implementation, and evaluation.
   3. Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider shall document evidence of compliance with the requirements of this chapter and rule 441—79.3(249A). The documentation or copies of the documentation must be maintained or be electronically accessible by the consumer-directed attendant care provider. Providers must use an electronic visit verification system that captures all documentation requirements of the Consumer-Directed Attendant Care (CDAC) Service Record (Form 470-4389) or use Form 470-4389. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:
   1. The service worker’s or case manager’s service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member’s needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.
   2. The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:
   1. Dressing.
   2. Bathing, shampooing, hygiene, and grooming.
   3. Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.
   4. Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).
(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member’s home.

(6) Housekeeping, laundry, and shopping essential to the member’s health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.
(9) Transportation costs.
(10) Wait times for any activity.

78.46(2) Home and vehicle modification. Covered home or vehicle modifications are physical modifications to the member’s home or vehicle that directly address the member’s medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member’s medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:
   (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
   (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
   (3) Grab bars and handrails.
   (4) Turnaround space adaptations.
   (5) Ramps, lifts, and door, hall and window widening.
   (6) Fire safety alarm equipment specific for disability.
   (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member’s disability.
   (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
   (9) Keyless entry systems.
   (10) Automatic opening device for home or vehicle door.
   (11) Special door and window locks.
   (12) Specialized doorknobs and handles.
   (13) Plexiglas replacement for glass windows.
   (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
   (15) Motion detectors.
   (16) Low-pile carpeting or slip-resistant flooring.
   (17) Telecommunications device for the deaf or hard of hearing.
   (19) New door opening.
   (20) Pocket doors.
   (21) Installation or relocation of controls, outlets, switches.
   (22) Air conditioning and air filtering if medically necessary.
   (23) Heightening of existing garage door opening to accommodate modified van.
   (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers’ compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to $6,592.66 per year may be made to certified providers upon satisfactory completion of the service.
h. Services shall be included in the member’s service plan and shall exceed the Medicaid state plan services.

78.46(3) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
   (1) The necessary components of a system are:
       1. An in-home medical communications transceiver.
       2. A remote, portable activator.
       3. A central monitoring station with backup systems staffed by trained attendants at all times.
       4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.
   (2) The service shall be identified in the member’s service plan.
   (3) A unit of service is a one-time installation fee or one month of service.
   (4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member’s age or disability.
   (1) The required components of the portable locator system are:
       1. A portable communications transceiver or transmitter to be worn or carried by the member.
       2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.
   (2) The service shall be identified in the member’s service plan.
   (3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.
   (4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) Specialized medical equipment.

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:
   (1) Provide for the health and safety of the member,
   (2) Are not ordinarily covered by Medicaid,
   (3) Are not funded by educational or vocational rehabilitation programs, and
   (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:
   (1) Electronic aids and organizers.
   (2) Medicine dispensing devices.
   (3) Communication devices.
   (4) Bath aids.
   (5) Noncovered environmental control units.
   (6) Repair and maintenance of items purchased through the waiver.

    c. Payment of up to $6,592.66 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.
    d. The need for specialized medical equipment shall be:
       (1) Documented by a health care professional as necessary for the member’s health and safety, and
       (2) Identified in the member’s service plan.
    e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) Transportation. Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.
78.46(6) Consumer choices option. The consumer choices option is service activities provided pursuant to subrule 78.34(13).

78.46(7) General service standards. All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member’s service plan.

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

(1) Any restrictions on the member’s rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.

(2) The need for the restriction.

(3) The less intrusive methods of meeting the need that have been tried but did not work.

(4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

(5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.

(6) The informed consent of the member.

(7) An assurance that the interventions and supports will cause no harm to the member.

(8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.

d. Services must be billed in whole units.

e. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 5597C, IAB 5/5/21, effective 7/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21; ARC 5896C, IAB 9/8/21, effective 8/17/21; ARC 6122C, IAB 12/29/21, effective 3/1/22]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.
Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider’s facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists’ usual patient care plans.

Acceptable professional training programs are:

1. A doctor of pharmacy degree program.
2. The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.
3. Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient’s primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

1. A patient evaluation by the pharmacist, including:
   1. Medication history;
   2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
   3. Assessment for the presence of untreated illness; and
   4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

2. A written report and recommendation from the pharmacist to the physician.

3. A patient care action plan developed by the PCM team with the patient’s agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient’s condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient’s status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.
d. **Preventive follow-up assessments.** These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient shall be reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 6310C, IAB 5/4/22, effective 7/1/22]

### 441—78.48(249A) Public health agencies.

Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0358C, IAB 10/3/12, effective 11/7/12]

### 441—78.49(249A) Infant and toddler program services.

Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

**78.49(1) Covered services.** Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

**78.49(2) Case management services.** Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. **Definition.** “Case management” means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. **Choice of provider.** Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child’s planned discharge if the child’s stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child’s planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. **Assessment.** The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child’s service needs, including the need for
any medical, educational, social, or other services. Assessment activities are defined to include the following:

1. Taking the child’s history;
2. Identifying the needs of the child;
3. Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
4. Completing documentation of the information gathered and the assessment results; and
5. Repeating the assessment every six months to determine whether the child’s needs or preferences have changed.

4. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

1. Include the child’s strengths and preferences;
2. Consider the child’s physical and social environment;
3. Specify goals of providing services to the child; and
4. Specify actions to address the child’s medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child’s authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

5. Other service components. Case management must include the following components:

1. Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.
2. Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:
   1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child’s plan of care.
   2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.
   3. Making referrals to providers for needed services.
   4. Scheduling appointments for the child.
   5. Facilitating the timely delivery of services.
   6. Arranging payment for medical transportation.
3. Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child’s eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:
   1. Whether services are being furnished in accordance with the child’s plan of care.
   2. Whether the services in the plan of care are adequate to meet the needs of the child.
   3. Whether there are changes in the needs or status of the child. If there are changes in the child’s needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.
4. Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child’s record, and preparing and responding to correspondence with the family and others.

6. Documentation of case management. For each child receiving case management, case records must document:

1. The name of the child;
2. The dates of case management services;
(3) The agency chosen by the family to provide the case management services;
(4) The nature, content, and units of case management services received;
(5) Whether the goals specified in the care plan have been achieved;
(6) Whether the family has declined services in the care plan;
(7) Time lines for providing services and reassessment; and
(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) Child's eligibility. Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) Delivery of services. Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) Remission of nonfederal share of costs. Payment for services shall be made only when the following conditions are met:
   a. Reserved.
   b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.
   c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) Covered services. Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.
   a. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.
   b. Payment for supplies shall be approved when the supplies are incidental to the patient’s care, e.g., syringes for injections, and do not exceed $25 per month. Durable medical equipment and other supplies are not covered as local education agency services.
   c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) Reserved.

78.50(3) Delivery of services. Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) Remission of nonfederal share of costs. Payment for services shall be made only when the following conditions are met:
   a. Reserved.
   b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.
   c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

[ARC 0065C, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service
638 facility, as defined at rule 441—77.45(249A), within the practitioner’s scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children’s mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children’s mental health waiver as established in 441—Chapter 83 and as identified in the member’s service plan. Effective March 17, 2022, payment shall only be made for services provided in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

78.52(1) General service standards. All children’s mental health waiver services must be provided in accordance with the following standards:
   a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.
   b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member’s service plan.
   c. All rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The member service plan or treatment plan shall include documentation of:
      (1) Any restrictions on the member’s rights, including the rights of privacy, dignity, respect, and freedom from coercion and restraint.
      (2) The need for the restriction.
      (3) The less intrusive methods of meeting the need that have been tried but did not work.
      (4) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.
      (5) Established time limits for periodic reviews to determine if the restriction is still necessary or can be terminated.
   (6) The informed consent of the member.
   (7) An assurance that the interventions and supports will cause no harm to the member.
   (8) A regular collection and review of data to measure the ongoing effectiveness of the restriction.
   d. Services must be billed in whole units.
   e. For all services with a 15-minute unit of service, the following rounding process will apply:
      (1) Add together the minutes spent on all billable activities during a calendar day for a daily total.
      (2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.
      (3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.
      (4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) Environmental modifications and adaptive devices.
   a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member’s home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:
      (1) Items ordinarily covered by Medicaid.
      (2) Items funded by educational or vocational rehabilitation programs.
      (3) Items provided by voluntary means.
      (4) Repair and maintenance of items purchased through the waiver.
      (5) Fencing.
   b. A unit of service is one modification or device.
c. For each unit of service provided, the case manager shall maintain in the member’s case file a signed statement from a mental health professional on the member’s interdisciplinary team that the service has a direct relationship to the member’s diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.52(3) Family and community support services. Family and community support services shall support the member and the member’s family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member’s and the family’s social and emotional strength.

a. Dependent on the needs of the member and the member’s family members individually or collectively, family and community support services may be provided to the member, to the member’s family members, or to the member and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the member’s interdisciplinary team pursuant to 441—Chapter 83.

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

1. Developing and maintaining a crisis support network for the member and for the member’s family.

2. Modeling and coaching effective coping strategies for the member’s family members.

3. Building resilience to the stigma of serious emotional disturbance for the member and the family.

4. Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.

5. Modeling and coaching the strategies and interventions identified in the member’s crisis intervention plan as defined in 441—24.1(225C) for life situations with the member’s family and in the community.

6. Developing medication management skills.

7. Developing personal hygiene and grooming skills that contribute to the member’s positive self-image.

8. Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed $1500 per member per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

1. The interdisciplinary team must have identified the transportation or therapeutic resource as a support need and included that need in the case manager’s plan.

2. The annual amount available for transportation and therapeutic resources must be listed in the member’s service plan.

3. The member’s parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the member or the member’s family or legal guardian.

4. The member’s Medicaid case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

5. The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

e. The following components are specifically excluded from family and community support services:

1. Vocational services.

2. Prevocational services.

3. Supported employment services.

4. Room and board.

5. Academic services.
(6) General supervision and care.

f. A unit of family and community support services is 15 minutes.

78.52(4) In-home family therapy. In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through Medicaid or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member’s current living situation.

a. Respite services provided outside the member’s home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member’s interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child’s day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

h. Respite services shall not be provided simultaneously with other residential, nursing, or home health aide services provided through the medical assistance program.

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

[ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 0707C, IAB 5/1/13, effective 7/1/13; ARC 0709C, IAB 5/1/13, effective 7/1/13; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—78.53(249A) Health home services.

78.53(1) Definitions.

“Chronic condition” means, for purposes of this rule, one of the conditions outlined in subparagraph 78.53(3) “a’(1).

“Chronic condition health home” means a health home that meets the criteria in 441—subrule 77.47(2).

“Health home” means a chronic condition health home or an integrated health home.

“Integrated health home” means a health home that meets the criteria in 441—subrule 77.47(3).

“Person-centered care plan” means a care plan created through the person-centered planning process, directed by the member or the member’s guardian or representative, for a member receiving non-intensive care management or chronic condition health home services, to identify the member’s strengths, capabilities, preferences, needs, goals, and desired outcomes.

“Person-centered service plan” or “service plan” means a service plan (1) created through the person-centered planning process in accordance with subrule 78.27(4), rule 441—83.127(249A) and 441—paragraph 90.4(1)“b’; (2) directed by the member or the member’s guardian or representative;
(3) for a member receiving intensive care management services; and (4) for the purposes of identifying the member’s strengths, capabilities, preferences, needs, and desired outcomes.

78.53(2) Covered services. A health home provides team-based, whole person, person-centered, coordinated care for all aspects of the member’s life and for transitions of care that the member may experience. A health home provides the following core services:

a. Comprehensive care management. Comprehensive care management is the initial and ongoing assessment and care management services aimed at the integration of primary, behavioral and specialty health care, and community support services, using a comprehensive person-centered care plan or service plan that addresses all clinical and nonclinical needs and promotes wellness and management of chronic conditions in pursuit of optimal health outcomes.

b. Care coordination. Care coordination includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support, lifestyle modification, and behavior changes. The health home must work with providers to coordinate, direct, and ensure results are communicated back to the health home.

c. Health promotion. Health promotion includes the education and engagement of a member in making decisions that promote health management, improved disease outcomes, disease prevention, safety, and an overall healthy lifestyle.

d. Comprehensive transitional care. Comprehensive transitional care is the facilitation of services for the member that provides support when the member is transitioning between levels of care (nursing facility, hospital, rehabilitation facility, community-based group home, family, self-care, or another health home).

e. Individual and family support. Individual and family support services include communication with the member and the member’s family and caregivers to maintain and promote quality of life, with particular focus on community living options. Support will be provided in a culturally appropriate manner.

f. Referral to community and social support services. Referral to community and social support services includes coordinating or providing recovery services and social health services available in the community, including resources for understanding eligibility for various health care programs, disability benefits, and identifying housing programs.

78.53(3) Member eligibility for health home services.

a. Chronic condition health home member eligibility criteria.

(1) To be eligible for chronic condition health home services, the member must have one of the following chronic conditions and be at risk of having a second chronic condition:

1. A mental health disorder.
2. A substance use disorder.
3. Asthma.
4. Diabetes.
5. Heart disease.
6. Being overweight, as evidenced by:
   • Having a body mass index (BMI) over 25 for an adult, or
   • Weighing over the 85th percentile for the pediatric population.
8. Chronic obstructive pulmonary disease.
9. Chronic pain.

(2) “At risk” means a documented family history of a verified heritable condition described above, a diagnosed medical condition with an established comorbidity to a condition described above, or a verified environmental exposure to an agent or condition known to be the cause of a condition from the conditions described above.
b. **Integrated health home eligible member criteria.** To be eligible for integrated health home services, the member must have a serious mental illness or serious emotional disturbance, as such terms are defined in 441—subrule 77.47(1).

78.53(4) **Member identification and enrollment.**

a. Eligible members are identified through a referral from the department, lead entity, primary care provider, hospital, other providers, the member, or the member’s authorized representative.

b. The health home confirms eligibility for health home services by obtaining assessment documentation from the member’s licensed mental health professional or the patient tiering assignment tool (PTAT).

c. The health home must explain to the member, in a format easily understood by the member, how the team works together with the member at the center to improve the member’s care, as well as all team member roles and responsibilities.

d. The health home must advise members of their ability and the process to opt out of health home services at any time.

e. Eligible members must agree to participate in the health home program, and the health home must document the member’s agreement in the member’s record before submitting an enrollment request. A member cannot be in more than one health home at the same time.

f. The health home must assess the member’s continued eligibility for health home services on an annual basis to ensure the member remains eligible to participate in the program.

78.53(5) **Health home documentation.** A health home must maintain adequate supporting documentation in readily reviewable form to ensure all state and federal requirements related to health home services have been met. All health home services must be documented in accordance with rule 441—79.3(249A). At a minimum, the health home must document the following:

a. **Eligibility.** Eligibility documentation includes but is not limited to the following:

   (1) How the member presented to the health home, including the referral.
   (2) Identified needs and plan to assess for eligibility.
   (3) Documentation that the member is eligible for health home services. If a member is not eligible, the health home must document the plan to support the member.

   (4) Qualifying diagnosis that makes the member eligible for health home services.
   (5) Member agreement and understanding of the program.
   (6) Enrollment request.
   (7) Enrollment with the health home.
   (8) Plan to complete the comprehensive assessment.
   (9) Documentation of continued eligibility, reviewed annually and maintained in the member’s service record.

b. **Comprehensive assessment.** The comprehensive assessment must include all aspects of a member’s life and satisfy the following requirements:

   (1) The comprehensive assessment must be completed within 30 days of enrollment, and at least every 365 days, or more frequently when the member’s needs or circumstances change significantly or at the request of the member or member’s support.

   (2) The comprehensive assessment for members enrolled to receive non-intensive care management or enrolled in the chronic condition health home must include:

   1. Assessment of the member’s current and historical information provided by the member, the lead entity, and other health care providers that support the member;
   2. Assessment of physical and behavioral health needs, medication reconciliation, functional limitations, and appropriate screenings;
   3. Assessment of the member’s social environment so that the plan of care incorporates areas of needs, strengths, preferences, and risk factors; and
   4. Assessment of the member’s readiness for self-management using screenings and assessments with standardized tools.

   (3) The comprehensive assessment for members enrolled to receive intensive care management must be in a format designated by the department and must include:
1. The member’s relevant history, including the findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to complete the comprehensive assessment.

2. The member’s physical, cognitive, and behavioral health care and support needs; strengths and preferences; available service and housing options; and, if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment.

3. Documentation that no state plan HCBS is provided that would otherwise be available to the member through other Medicaid services or other federally funded programs.

4. For members receiving state plan HCBS and HCBS approved under 441—Chapter 83, documentation that HCBS provided through the state plan and waiver are not duplicative.
   c. Person-centered service plan and person-centered care plan.
      (1) For members receiving non-intensive care management or enrolled in the chronic condition health home, documentation must include a person-centered care plan that meets the requirements as defined in subrule 78.53(1) and the health home state plan amendment.
      (2) For members receiving intensive care management, documentation must include a service plan that meets the requirements of rule 441—78.27(249A) or 441—83.127(249A) and 441—paragraph 90.4(1)“b.”
      (3) Documentation must reflect an update of the plan no less often than every 365 days and when significant changes occur in the member’s support needs, situation, condition, or circumstances.
   d. Core services. Documentation must reflect monthly provision of one of the six core health home services as outlined in subrule 78.53(2).
   e. Intensive health home services. A health home must provide documentation to justify provision of more intensive health home services, including documentation that the member is enrolled to receive services through the HCBS habilitation or HCBS children’s mental health waiver programs.
   f. Continuity of care.
      (1) The health home must maintain a continuity of care document in each enrolled member’s record and provide this document to the department, the lead entity, and the member’s treating providers upon request.
      (2) The continuity of care document must include, at a minimum, all aspects of the member’s medical and behavioral health needs, treatment plan, and medication list.
   g. Disenrollment. Members are able to opt out of health home services at any time. The health home must document a member’s request to disenroll from health home services, the reason for disenrollment, how the member’s needs will be supported after disenrollment, and that the health home has advised the member of the ability to re-enroll if circumstances change.

78.53(6) Payment.
   a. Payment will be made for health home services when:
      (1) The member is eligible for Medicaid and enrolled in the health home for the month of service, and
      (2) The health home provides at least one of the six core health home services described in subrule 78.53(2) during the month, and
      (3) The health home maintains the documentation outlined in subrule 78.53(5).
   b. A unit of service is one member month.
   c. The health home must report the informational-only code in addition to the billing procedure code and modifier for one or more of the core services provided to the member during the month on the claim for payment.

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

[ARC 6310C, IAB 5/4/22, effective 7/1/22]
441—78.54(249A) **Speech-language pathology services.** Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

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

[ARC 0360C, IAB 10/3/12, effective 12/1/12; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—78.55(249A) **Services rendered via telehealth.** An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

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

[ARC 2166C, IAB 9/30/15, effective 11/4/15; ARC 6310C, IAB 5/4/22, effective 7/1/22]

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

78.56(1) **Definitions.**

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

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

“Health care” means the services provided by trained and licensed health care professionals to restore or maintain the member’s health.

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

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

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

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

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

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

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

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

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or
(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

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

d. Needs assessment. The member shall have an assessment of need completed prior to admission. The member shall have the Mayo-Portland Adaptability Inventory (MPAI) assessment completed by a qualified trained assessor. The assessment of need shall document the member’s need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise or the member’s managed care organization has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had the MPAI assessment completed within the 90 days prior to admission. In addition to the functional assessment, the needs assessment will have been completed and will include the assessment of a member’s individual physical, emotional, cognitive, medical and psychosocial residuals related to the member’s brain injury and must include the following:

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

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

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

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

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

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

(7) The member’s access to transportation.

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

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

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

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

78.56(3) Covered services.

a. Service setting.

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

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

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

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

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

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

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

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

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

(6) Behavioral and cognitive programming and supports;

(7) Medication management and consultation with pharmacy;
(8) Health and wellness management including dietary and nutritional programming;
(9) Progressive physical strengthening, fitness and retraining;
(10) Assistance with obtaining and use of assistive technology;
(11) Sobriety support development;
(12) Assistance with the self-identification of antecedent triggers;
(13) Assistance with preparation for transition to less intensive services including accessing the community;
(14) Flexibility in programming to meet individual needs;
(15) Assistance with re-learning coping and compensatory strategies;
(16) Support and assistance in seeking substance abuse and co-occurring disorders services;
(17) Support and assistance with obtaining legal consultation and services;
(18) Assistance with community accessibility and safety;
(19) Assistance with re-learning household maintenance;
(20) Assistance with recreational and leisure skill development;
(21) Assistance with the development and application of self-advocacy skills to navigate the service system;
(22) Opportunities to learn about brain injury and individual needs following brain injury;
(23) Support for carrying out the member’s individual goals in the rehabilitation treatment plan;
(24) Assistance with pursuit of education and employment goals;
(25) Protective oversight in the residential setting and community;
(26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;
(27) Transitional support and training;
(28) Transportation essential to the attainment of the member’s individual goals in the rehabilitation treatment plan;
(29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member’s own home with or on behalf of the member and may include:
(1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;
(2) Modifying or adapting the member’s environment to improve overall functioning;
(3) Compensatory strategies to assist in managing ADLS (activities of daily living);
(4) Behavioral supports;
(5) Assistance with obtaining and use of assistive technology;
(6) Assistance with the self-identification of antecedent triggers;
(7) Flexibility in programming to meet the member’s individual needs;
(8) Assistance with re-learning coping and compensatory strategies;
(9) Assistance with the development and application of self-advocacy skills to navigate the service system;
(10) Support for carrying out the member’s individual goals in the rehabilitation treatment plan;
(11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;
(12) Transitional support and training;
(13) Transportation essential to the attainment of the member’s individual goals in the rehabilitation treatment plan.

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

e. Initial treatment plan. Within 30 days of admission, the provider shall submit the member’s treatment plan to the IME medical services unit.
(1) The IME medical services unit will approve the provider’s treatment plan if:
   1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);
   2. The treatment plan is consistent with the written diagnosis and treatment recommendations
      made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or
      D.O.;
   3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its
      purpose;
   4. The provider can demonstrate that the provider possesses the skills and resources necessary to
      implement the plan; and
   5. The treatment plan does not exceed 180 days in duration.

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

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

   (g) Quality review. The IME medical services unit may perform the quality review to evaluate:
   (1) The time elapsed from referral to rehabilitation treatment plan development;
   (2) The continuity of treatment;
   (3) The length of stay per member;
   (4) The affiliation of the medical professional recommending services with the neurobehavioral
   rehabilitation services provider;
   (5) Gaps in service;
   (6) The results achieved;
   (7) Member and stakeholder satisfaction;
   (8) The provider’s compliance with standards listed in rule 441—77.54(249A).

   78.56(4) Medical necessity. Nothing in this rule shall be deemed to exempt coverage of
   community-based neurobehavioral rehabilitation services from the requirement that services be
   medically necessary. “Medically necessary” means that the service is:
   (a) Consistent with the diagnosis and treatment of the member’s condition;
   (b) Required to meet the medical needs of the member and is needed for reasons other than the
      convenience of the member or the member’s caregiver;
   (c) The least costly type of service that can reasonably meet the medical needs of the member; and
   (d) In accordance with the standards of good medical practice. The standards of good practice for
      each field of medical and remedial care covered by the Iowa Medicaid program are those standards of
      good practice identified by:
      (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and
      (2) The professional literature regarding best practices in the field.

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

   This rule is intended to implement Iowa Code section 249A.4.
   [ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 4792C, IAB 12/4/19, effective 1/8/20; ARC 6310C, IAB 5/4/22, effective 7/1/22]

441—78.57(249A) Child care medical services. Payments will be made to licensed child care centers
that provide medical services in addition to child care. Medically necessary services are provided under
a plan of care that is developed by licensed professionals within their scope of practice and authorized
by the member’s physician. The services include and implement a comprehensive protocol of care that
is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal
care, psychosocial and developmental therapies required by the medically dependent or technologically
dependent child served.

78.57(1) Nursing services are services which are provided by a registered nurse or a licensed
practical nurse under the direction of the member’s physician to a member in a licensed child care
center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member’s physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member’s plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.57(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member’s plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.57(4) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member’s physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member’s plan of care and authorized by a physician. Developmental therapies include activities based on the individual’s needs such as fine motor, gross motor, and receptive expressive language.

78.57(5) “Medically necessary” means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.57(6) Requirements.
   a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.
   b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department’s designated review agent prior to payment.
   c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department’s designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department’s designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:
      (1) Place of service.
      (2) Type of service to be rendered and the treatment modalities being used.
      (3) Frequency of the services.
      (4) Assistance devices to be used.
      (5) Date on which services were initiated.
      (6) Progress of member in response to treatment.
      (7) Medical supplies to be furnished.
      (8) Member’s medical condition as reflected by the following information, if applicable:
         1. Dates of prior hospitalization.
         2. Dates of prior surgery.
         3. Date last seen by a primary care provider.
4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
5. Prognosis.
6. Functional limitations.
8. Date of last episode of acute recurrence of illness or symptoms.
10. Discipline of the person providing the service.
11. Certification period.
12. Form 470-5686 is utilized during the prior authorization review.

78.57(7) Nursing, personal care, and psychosocial services do not include:

a. Services provided to members aged 21 and older.

b. Services that require prior authorizations that are provided without regard to the prior authorization process.

c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).

d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).

e. Transportation services.

441—78.58(249A) Qualified Medicare beneficiary (QMB) provider services.

78.58(1) Payment. Payment will be made to QMB providers for a QMB-eligible member’s coinsurance, copayment, and deductible for Medicare-covered services. The eligible member may be responsible for copayments pursuant to 441—subrule 79.1(13).

78.58(2) Definitions.

“Coinsurance” means a percentage of costs of a covered health care service that has to be paid.

“Copayment” means a fixed amount a member pays for a covered health care service.

“Deductible” means the amount paid for covered health care services before the insurance plan will effect payment.

“Medicare cost sharing” means the Medicare member’s responsibility for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“Qualified Medicare beneficiary” or “QMB” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

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

441—78.59(249A) Health insurance premium payment (HIPP) provider services.

78.59(1) Reimbursement. A HIPP provider may bill the department for the HIPP-eligible member’s out-of-pocket cost-sharing obligations. Reimbursement of claims is limited to in-network coinsurance, copayments, and deductibles of the HIPP-eligible member’s health insurance, paid for through the HIPP program. The HIPP-eligible member may be responsible for a copayment pursuant to 441—subrule 79.1(13).

78.59(2) Definitions.

“Coinsurance” means a percentage of costs of a covered health care service that has to be paid.

“Copayment” means a fixed amount a member pays for a covered health care service.

“Cost sharing” means the member’s health insurance in-network responsibility for a covered service. “Cost sharing” includes coinsurance, copayments, and deductibles.
“Deductible” means the amount paid for covered health care services before the insurance plan will effect payment.

“Eligible member” means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department’s HIPP program prescribed under rule 441—75.21(249A).

“Health insurance premium payment (HIPP) program” or “HIPP program” has the same meaning as provided in rule 441—75.21(249A).

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

[ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—78.60(249A) Crisis response services. Payment will be made to providers (eligible pursuant to rule 441—77.55(249A)) of crisis response services, crisis stabilization community-based services, and crisis stabilization residential services delivered as set forth in 441—Chapter 24, Division II.

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

[ARC 3551C, IAB 1/3/18, effective 2/7/18]

441—78.61(249A) Subacute mental health services. Payment will be made to providers (eligible pursuant to rule 441—77.56(249A)) for the provision of subacute mental health care facility services that meet the standards outlined in 481—Chapter 71.

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

[ARC 3551C, IAB 1/3/18, effective 2/7/18]

These rules are intended to implement Iowa Code chapter 249A.

[Filed 3/11/70; amended 3/20/74]

[Filed 11/25/75, Notice 10/6/75—published 12/15/75, effective 1/19/76]

[Filed emergency 12/23/75—published 1/12/76, effective 2/1/76]

[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]

[Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]

[Filed 4/30/76, Notice 3/22/76—published 5/17/76, effective 6/21/76]

[Filed emergency 6/9/76—published 6/28/76, effective 6/9/76]

[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]

[Filed emergency 12/17/76—published 1/12/77, effective 1/1/77]

[Filed 2/25/77, Notice 1/12/77—published 3/23/77, effective 4/27/77]

[Filed emergency 4/13/77—published 5/4/77, effective 4/13/77]

[Filed emergency 7/20/77—published 8/10/77, effective 7/20/77]

[Filed emergency 8/24/77—published 9/21/77, effective 8/26/77]

[Filed emergency 9/1/77—published 9/21/77, effective 9/1/77]

[Filed 11/22/77, Notice 9/7/77—published 12/14/77, effective 2/1/78]

[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]

[Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]

[Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]

[Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]

[Filed emergency 6/9/78—published 6/28/78, effective 7/5/78]

[Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]

[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]

[Filed 8/18/78, Notice 5/31/78—published 9/6/78, effective 10/11/78]

[Filed 9/12/78, Notice 4/19/78—published 10/4/78, effective 11/8/78]

[Filed 9/12/78, Notice 7/26/78—published 10/4/78, effective 12/1/78]

[Filed 11/20/78, Notice 10/4/78—published 12/13/78, effective 1/17/79]

[Filed 12/6/78, Notice 10/4/78—published 12/27/78, effective 2/1/79]

[Filed 12/6/78, Notice 5/31/78—published 12/27/78, effective 2/1/79]


[Filed emergency 1/31/79—published 2/21/79, effective 3/8/79]

[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
[Filed 10/24/79, Notice 5/30/79—published 11/14/79, effective 12/19/79]
[Filed 10/24/79, Notice 8/22/79—published 11/14/79, effective 12/19/79]
[Filed emergency 1/23/80—published 2/20/80, effective 1/23/80]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed emergency 7/3/80—published 7/23/80, effective 7/8/80 to 1/1/81]
[Filed 7/3/80, Notice 4/14/80—published 7/23/80, effective 8/27/80]
[Filed 9/25/80, Notice 8/6/80—published 10/15/80, effective 11/19/80]
[Filed without Notice 9/26/80—published 10/15/80, effective 12/1/80]
[Filed 10/23/80, Notice 7/23/80—published 11/12/80, effective 12/17/80]
[Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
[Filed 12/19/80, Notices 10/15/80, 10/29/80—published 1/7/81, effective 2/11/81]
[Filed emergency 1/20/81—published 2/18/81, effective 1/20/81]
[Filed 2/12/81, Notice 11/12/80—published 3/4/81, effective 7/1/81]
[Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed emergency 8/24/81 after Notice 7/8/81—published 9/16/81, effective 9/1/81]
[Filed 10/23/81, Notice 9/2/81—published 11/11/81, effective 1/1/82]
[Filed emergency 12/3/81—published 12/23/81, effective 1/1/82]
[Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
[Filed 1/28/82, Notice 11/25/81—published 2/17/82, effective 4/1/82]
[Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]
[Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
[Filed 4/5/82, Notice 1/20/82—published 4/28/82, effective 6/2/82]
[Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]
[Filed 7/30/82, Notices 3/3/82, 4/28/82—published 8/18/82, effective 10/1/82]
[Filed emergency 9/23/82 after Notice 6/23/82—published 10/13/82, effective 10/1/82]
[Filed 11/5/82, Notice 9/15/82—published 11/24/82, effective 1/1/83]
[Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 7/29/83—published 8/17/83, effective 8/1/83]17 10
[Filed 7/29/83, Notice 5/25/83—published 8/17/83, effective 10/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 10/28/83, Notices 8/31/83, 9/14/83—published 11/23/83, effective 1/1/84]17 10
[Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 5/4/84, Notice 3/14/84—published 5/23/84, effective 7/1/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed 11/1/84, Notice 9/12/84—published 11/21/84, effective 1/1/85]
[Filed 12/11/84, Notice 10/10/84—published 1/2/85, effective 3/1/85]
[Filed 1/21/85, Notice 10/24/84—published 2/13/85, effective 4/1/85]
[Filed 4/29/85, Notice 12/19/84—published 5/22/85, effective 7/1/85]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed 5/29/85, Notice 3/27/85—published 6/19/85, effective 8/1/85]
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[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
[Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]¹
[Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
[Filed 4/11/91, Notice 3/6/91—published 5/1/91, effective 7/1/91]
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
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[Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
[Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92]²
[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
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[Filed 7/17/92, Notices 5/27/92—published 8/5/92, effective 10/1/92]³
[Filed emergency 8/14/92—published 9/2/92, effective 9/1/92]
[Filed 8/14/92, Notices 6/24/92, 7/8/92, 8/5/92—published 9/2/92, effective 11/1/92]
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[Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
[Filed emergency 1/16/02—published 2/6/02, effective 2/1/02]
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[Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
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[Filed 1/16/04, Notices 9/17/03, 10/29/03—published 2/4/04, effective 3/10/04]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
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Filed 11/12/08, Notice 9/24/08—published 12/3/08, effective 2/1/09
Filed 12/11/08, Notice 9/10/08—published 1/14/09, effective 2/18/09
Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09
Filed ARC 7548B (Notice ARC 7369B, IAB 11/19/08, IAB 2/11/09, effective 4/1/09)
Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09
Filed Emergency After Notice ARC 8008B (Notice ARC 7771B, IAB 5/20/09), IAB 7/29/09, effective 8/1/09
Filed ARC 8097B (Notice ARC 7816B, IAB 6/3/09), IAB 9/9/09, effective 11/1/09
Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/1/09
Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09
Filed ARC 8504B (Notice ARC 8247B, IAB 10/21/09), IAB 2/10/10, effective 3/22/10
Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10
Filed Emergency After Notice ARC 8714B (Notice ARC 8538B, IAB 2/24/10), IAB 5/5/10, effective 5/1/10
Filed ARC 8993B (Notice ARC 8722B, IAB 5/5/10), IAB 8/11/10, effective 10/1/10
Filed ARC 8994B (Notice ARC 8756B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10
Filed ARC 9045B (Notice ARC 8832B, IAB 6/2/10), IAB 9/8/10, effective 11/1/10
Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10
Filed ARC 9175B (Notice ARC 8975B, IAB 7/28/10), IAB 11/3/10, effective 1/1/11
Filed Emergency ARC 9256B, IAB 12/1/10, effective 1/1/11
Filed Emergency ARC 9311B, IAB 12/29/10, effective 1/1/11
Filed ARC 9315B (Notice ARC 9111B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11
Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11
Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11
Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11, effective 4/1/11
[Editorial change: IAC Supplement 4/20/11]
Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11
Filed ARC 9588B (Notice ARC 9367B, IAB 2/9/11; Amended Notice ARC 9448B, IAB 4/6/11), IAB 6/29/11, effective 9/1/11
Filed Emergency After Notice ARC 9649B (Notice ARC 9538B, IAB 6/1/11), IAB 8/10/11, effective 8/1/11
Filed ARC 9650B (Notice ARC 9497B, IAB 5/4/11), IAB 8/10/11, effective 10/1/11
Filed Emergency ARC 9699B, IAB 9/7/11, effective 9/1/11
Filed Emergency ARC 9702B, IAB 9/7/11, effective 9/1/11
Filed Emergency ARC 9704B, IAB 9/7/11, effective 9/1/11
Filed Emergency ARC 9834B, IAB 11/2/11, effective 11/1/11
Filed ARC 9882B (Notice ARC 9700B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12
Filed ARC 9883B (Notice ARC 9703B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12
Filed ARC 9884B (Notice ARC 9705B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12
Filed ARC 9981B (Notice ARC 9835B, IAB 11/2/11), IAB 2/8/12, effective 3/14/12
Filed ARC 0065C (Notice ARC 9940B, IAB 12/28/11), IAB 4/4/12, effective 6/1/12
Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12
Filed Emergency ARC 0194C, IAB 7/11/12, effective 7/1/12
Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective 7/1/12
Filed ARC 0305C (Notice ARC 0144C, IAB 5/30/12), IAB 9/5/12, effective 11/1/12
Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12
Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12
Filed ARC 0354C (Notice ARC 0195C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12
Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12
Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13
Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13
Filed ARC 0631C (Notice ARC 0497C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13
Filed ARC 0632C (Notice ARC 0496C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13
Filed ARC 0707C (Notice ARC 0567C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13
Filed ARC 0709C (Notice ARC 0589C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13
Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13
Filed ARC 0823C (Notice ARC 0649C, IAB 3/20/13), IAB 7/10/13, effective 9/1/13
Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13
Filed Emergency ARC 0842C, IAB 7/24/13, effective 7/1/13
Filed Emergency ARC 0844C, IAB 7/24/13, effective 7/1/13
Filed Emergency ARC 0846C, IAB 7/24/13, effective 7/1/13
Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13
Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13
Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13
Filed ARC 1052C (Notice ARC 0845C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13
Filed ARC 1056C (Notice ARC 0841C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13
Filed ARC 1054C (Notice ARC 0843C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13
Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13
Filed ARC 1151C (Notice ARC 0920C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14
Filed ARC 1264C (Notice ARC 1161C, IAB 10/30/13), IAB 1/8/14, effective 3/1/14
Filed ARC 1297C (Notice ARC 1185C, IAB 11/13/13), IAB 2/5/14, effective 4/1/14
Filed Emergency After Notice ARC 1610C (Notice ARC 1510C, IAB 6/25/14), IAB 9/3/14, effective 8/13/14
Filed ARC 1696C (Notice ARC 1620C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15
Filed ARC 1850C (Notice ARC 1729C, IAB 11/12/14), IAB 2/4/15, effective 4/1/15
Filed ARC 1976C (Notice ARC 1901C, IAB 3/4/15), IAB 4/29/15, effective 7/1/15
Filed Emergency After Notice ARC 2050C (Notice ARC 1982C, IAB 4/29/15), IAB 7/8/15, effective 7/1/15
Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15
[Filed ARC 2166C (Notice ARC 2096C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]

[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]

[Filed ARC 2340C (Notice ARC 2115C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]

[Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]

[Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]

[Filed Emergency ARC 2848C, IAB 12/7/16, effective 11/15/16]

[Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]

[Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]

[Filed ARC 3005C (Notice ARC 2897C, IAB 1/18/17), IAB 3/29/17, effective 5/3/17]

[Filed ARC 3184C (Notice ARC 2920C, IAB 2/1/17), IAB 7/5/17, effective 8/9/17]

[Filed Emergency ARC 3481C, IAB 12/6/17, effective 12/1/17]

[Filed ARC 3494C (Notice ARC 3321C, IAB 9/27/17), IAB 12/6/17, effective 1/10/18]

[Filed ARC 3551C (Notice ARC 3439C, IAB 11/8/17), IAB 1/3/18, effective 2/7/18]

[Filed ARC 3552C (Notice ARC 3374C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]

[Filed ARC 3553C (Notice ARC 3419C, IAB 10/25/17), IAB 1/3/18, effective 2/7/18]

[Filed ARC 3790C (Notice ARC 3476C, IAB 12/6/17; Amended Notice ARC 3602C, IAB 1/31/18), IAB 5/9/18, effective 6/13/18]

[Filed ARC 3874C (Notice ARC 3784C, IAB 5/9/18), IAB 7/4/18, effective 8/8/18]

[Filed ARC 4430C (Notice ARC 4288C, IAB 2/13/19), IAB 5/8/19, effective 7/1/19]

[Filed ARC 4575C (Notice ARC 4444C, IAB 5/22/19), IAB 7/31/19, effective 9/4/19]

[Filed ARC 4792C (Notice ARC 4628C, IAB 8/28/19), IAB 12/4/19, effective 1/8/20]

[Filed ARC 4897C (Notice ARC 4739C, IAB 11/6/19), IAB 2/12/20, effective 3/18/20]

[Filed ARC 4899C (Notice ARC 4763C, IAB 11/20/19), IAB 2/12/20, effective 3/18/20]

[Filed ARC 5175C (Notice ARC 4964C, IAB 3/11/20), IAB 9/9/20, effective 6/1/21]

[Filed ARC 5305C (Notice ARC 5167C, IAB 9/9/20), IAB 12/2/20, effective 2/1/21]

[Filed ARC 5307C (Notice ARC 5166C, IAB 9/9/20), IAB 12/2/20, effective 2/1/21]

[Filed ARC 5362C (Notice ARC 5229C, IAB 10/21/20), IAB 12/30/20, effective 3/1/21]

[Filed ARC 5364C (Notice ARC 5228C, IAB 10/21/20), IAB 12/30/20, effective 3/1/21]

[Filed ARC 5418C (Notice ARC 5276C, IAB 11/18/20), IAB 2/10/21, effective 4/1/21]

[Filed ARC 5487C (Notice ARC 5336C, IAB 12/16/20), IAB 3/10/21, effective 4/14/21]

[Filed ARC 5597C (Notice ARC 5437C, IAB 2/10/21), IAB 5/5/21, effective 7/1/21]

[Filed ARC 5808C (Notice ARC 5619C, IAB 5/19/21), IAB 7/28/21, effective 9/1/21]

[Filed ARC 5809C (Notice ARC 5623C, IAB 5/19/21), IAB 7/28/21, effective 9/1/21]

[Filed Emergency ARC 5896C, IAB 9/8/21, effective 8/17/21]

[Filed ARC 5889C (Notice ARC 5706C, IAB 6/16/21), IAB 9/8/21, effective 11/1/21]

[Filed ARC 6122C (Notice ARC 5903C, IAB 9/8/21), IAB 12/29/21, effective 3/1/22]

[Filed ARC 6222C (Notice ARC 6081C, IAB 12/15/21), IAB 3/9/22, effective 5/1/22]

[Filed ARC 6310C (Notice ARC 6206C, IAB 2/23/22), IAB 5/4/22, effective 7/1/22]

[Filed ARC 6389C (Notice ARC 6313C, IAB 5/4/22), IAB 6/29/22, effective 9/1/22]

[Filed ARC 6390C (Notice ARC 6286C, IAB 4/6/22), IAB 6/29/22, effective 9/1/22]
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**.

**Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.**

Two or more ARCs

July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.

March 18, 2020, effective date of **ARC 4899C** [amendments to chs 78, 79] delayed until the adjournment of the 2021 session of the General Assembly by the Administrative Rules Review Committee at its meeting held March 6, 2020; delay lifted at the meeting held August 11, 2020, except with respect to amendments to 78.2(6). Effective date of amendments to 78.2(6) remains delayed until the adjournment of the 2021 session of the General Assembly.
CHAPTER 81
NURSING FACILITIES
[ Prior to 7/1/83 Social Services[770] Ch 81]
[ Prior to 2/1/87, Human Services[498] ]

DIVISION I
GENERAL POLICIES

441—81.1(249A) Definitions.

"Abuse" means any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 or 728.12, subsection 1, or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident which means the act or process of taking unfair advantage of a resident or the resident's physical or financial resources for one's own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident's life or health.

"Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the resident is incapacitated.

"Allowable costs" means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in rules.

"Beginning eligibility date" means date of an individual's admission to the facility or date of eligibility for medical assistance, whichever is the later date.

"Case mix" means a measure of the intensity of care and services used by similar residents in a facility.

"Case-mix index" means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

"Civil penalty" shall mean a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

"Clinical experience" means application or learned skills for direct resident care in a nursing facility.

"Clock hour" means 60 minutes.

"Complete replacement" means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

"Cost normalization" refers to the process of removing cost variations associated with different levels of resident case mix. Normalized cost is determined by dividing a facility’s per diem direct care component costs by the facility cost report period case-mix index.

"Denial of critical care" is a pattern of care in which the resident’s basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident’s serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

"Department" means the Iowa department of human services.
“Direct care component” means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services. “Direct care component” also includes costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

“Discharged resident” means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility. When a resident is discharged, the facility shall notify the department via Form 470-0042, Case Activity Report.

“Facility” means a licensed nursing facility certified in accordance with the provisions of 42 CFR 483.5 as amended to December 4, 2017, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

“Facility-based nurse aide training program” means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

“Facility cost report period case-mix index” is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

“Facilitywide average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

“Informed consent” means a resident’s agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

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

“Laboratory experience” means practicing care-giving skills prior to contact in the clinical setting.

“Level I review” means screening to identify persons suspected of having mental illness or intellectual disability as defined in 42 CFR 483.102 as amended to July 1, 2014.

“Level II review” means the evaluation of a person identified in a Level I review to determine whether nursing facility services and specialized services are needed.

“Major renovations” means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds $1.5 million. The $1.5 million threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility’s financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the $1.5 million threshold.

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

“Medicaid average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

“Minimum data set” or “MDS” refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility’s case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.6(16) “b,” for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.6(16) “c” and “e,” the excess payment allowance pursuant to paragraph 81.6(16) “d,” and the limits on reimbursement components pursuant to paragraph 81.6(16) “f.” MDS is described in subrule 81.13(9).
“Minimum food, shelter, clothing, supervision, physical or mental health care, or other care” means that food, shelter, clothing, supervision, physical or mental health care, or other care which, if not provided, would constitute denial of critical care.

“Mistreatment” means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact which is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

“New construction” means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

“Non-direct care component” means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

“Non-facility-based nurse aide training program” means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

“Nurse aide” means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

“Nurse aide registry” means Nurse Aide Registry, Department of Inspections and Appeals, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

“Nurse aide training and competency evaluation programs (NATCEP)” are educational programs approved by the department of inspections and appeals for nurse aide training as designated in subrule 81.16(3).

“Nursing facility level of care” means that the following conditions are met:
1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“PASRR” means a Level I screening or a Level II evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C, as amended to July 1, 2014.

“Patient-day-weighted median cost” means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

“Physical abuse” means any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

“Physical injury” means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue which results in the death of the person who has sustained the damage.

“Poor performing facility (PPF)” is a facility designated by the department of inspections and appeals as a poor performing facility (PPF) based on surveys conducted by the department of inspections and appeals pursuant to subrule 81.13(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:
1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.13(19)“o.”
“Primary instructor” means a registered nurse responsible for teaching a state-approved nurse aide training course.

“Program coordinator” means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

“Rate determination letter” means the letter that is distributed quarterly by the Iowa Medicaid enterprise to each nursing facility notifying the facility of the facility’s Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
   a. A physician order for all skilled services.
   b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
   c. An individualized care plan that identifies support needs.
   d. Confirmation that skilled services are provided to the member.
   e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
   f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Skills performance record” means a record of major duties and skills taught which consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

“Special population nursing facility” refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 30 and under and require the skilled level of care.
2. Seventy percent of the residents served require the skilled level of care for neurological disorders.
3. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness.
4. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with medical complexity.

“Surgical or other invasive procedure” means an operative procedure in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Surgical or other invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. Surgical or other invasive procedures include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) published by the American Medical Association and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. Surgical or other invasive procedures include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. “Surgical or other invasive procedure” does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

“Terminated from the Medicare or Medicaid program” means a facility has lost the final appeal to which it is entitled.
“Testing entity” means a person, agency, institution, or facility approved by the department of inspections and appeals to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) “a,” and 249A.4.

[ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 9994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3718C, IAB 3/28/18, effective 5/2/18; ARC 3717C, IAB 3/28/18, effective 7/1/18; ARC 4052C, IAB 10/10/18, effective 9/12/18]

441—81.2 Reserved.

441—81.3(249A) Initial approval for nursing facility care.

81.3(1) Need for nursing facility care. Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care, subject to paragraph 81.3(1)“b,” shall be made for the department by the Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. For residents subject to a Level I PASRR review pursuant to subrule 81.3(3), the level of care determination shall be made as part of the Level II PASRR review, based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

c. Adverse level of care decisions may be appealed to the department pursuant to 441—Chapter 7.

81.3(2) Reserved.

81.3(3) Preadmission review. The department’s contractor for PASRR screening and evaluation shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person’s care. When a Level I review identifies evidence for the presence of mental illness or intellectual disability, the department’s contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

a. Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that, in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness or intellectual disability is normally not needed.

(1) The person’s attending physician certifies that the person is terminally ill with death expected within six months, the person requires nursing care or supervision due to the person’s physical condition, and the person is not a danger to self or others. If the person’s nursing facility stay exceeds six months, a Level II review must be completed.

(2) The severity of the person’s illness results in impairment so severe that the person could not be expected to benefit from specialized services, and the person does not present a danger to self or others. This category includes persons who are comatose, who function at brain-stem level, who are ventilator-dependent, or who have diagnoses such as Parkinson’s disease, Huntington’s chorea, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF).

(3) The person is suffering from delirium. Exemptions made on a basis of delirium are valid until the delirium clears or for seven days, whichever is sooner.

(4) The person is in an emergency situation that requires protective services with placement in the nursing facility. A Level II review must be completed if the admission lasts more than seven days.

(5) The admission is for the purpose of providing respite to the person’s caregiver. If the nursing facility stay exceeds 30 days, a Level II review must be completed.

(6) The person has dementia in combination with an intellectual disability.
(7) The person has been approved for specialized services in another facility based on a previous Level II evaluation, the specialized services still meet the person’s needs, and the receiving facility agrees to provide the specialized services.

(8) The person is transferring directly from receiving acute hospital inpatient care and requires nursing facility services for the same acute physical illness for which hospital care was received, and the person’s attending physician certifies before the admission that the person is likely to require less than 30 days of nursing facility services. If the person is later found to require more than 30 days of nursing facility care, a Level II review must be completed within 40 calendar days of the person’s admission date.

(9) The person:
1. Is transferring to a nursing facility directly from receiving acute hospital inpatient care, and
2. Requires nursing facility services for convalescence from the same acute physical illness for which the person received hospital care, and
3. Is clearly sufficiently psychiatrically and behaviorally stable enough for nursing facility admission, and
4. Before entering the facility, has been certified by the attending physician as likely to require less than 60 days of nursing facility services.

b. Outcome of Level II review. The Level II review shall determine:

(1) Whether nursing facility care or skilled nursing care is medically necessary and appropriate under 441—subrules 79.9(1) and 79.9(2) for the person seeking admission;

(2) Whether the person seeking admission needs specialized services for mental illness as defined in paragraph 81.13(14)“b,” using the procedures set forth in 42 CFR 483.134 as amended to July 1, 2014; and

(3) Whether the person seeking admission needs specialized services for intellectual disability as defined in paragraph 81.13(14)“c,” using the procedures set forth in 42 CFR 483.136 as amended to July 1, 2014.

c. The department’s division of mental health and disability services or its designee shall review each Level II evaluation and plan for obtaining needed specialized services before the person’s admission to a nursing facility to determine whether nursing facility care or skilled nursing care is medically necessary and whether the nursing facility is an appropriate placement.

d. Nursing facility payment under the Iowa Medicaid program will be made for Medicaid members residing in the nursing facility:

(1) Only if a Level I review was completed prior to admission;

(2) For persons with mental illness or intellectual disability, only if a Level II review has been completed, or an exception under paragraph 81.3(3)“a” has been approved, and it is determined by the division of mental health and disability services that nursing facility care or skilled nursing care is medically necessary and appropriate and that the person’s treatment needs related to a mental illness or intellectual disability will be or are being met.

e. Adverse PASRR decisions may be appealed to the department pursuant to 441—Chapter 7.

f. A nursing facility requesting an administrative hearing regarding a PASRR determination must have the prior, express, signed, written consent of the resident or the resident’s lawfully appointed guardian to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the nursing facility submits a document providing such resident’s consent to the request for a state fair hearing. The document must specifically inform the resident that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the resident’s knowledge of the potential for PHI to become public and that the resident knowingly, voluntarily, and intelligently consents to the nursing facility’s bringing the state fair hearing on the resident’s behalf.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)“a” and 249A.4.
441—81.4(249A) Arrangements with residents.

81.4(1) Reserved.

81.4(2) Financial participation by resident. A resident’s payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident’s client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

81.4(3) Personal needs account. When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident’s personal needs funds. (See subrule 81.13(5)”c.”) The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.6(249A) if the service cannot be obtained free of charge. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident’s personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident’s total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident’s signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident’s benefit.

c. Personal funds shall only be turned over to the resident, the resident’s guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident’s files.

d. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department’s representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

e. Upon a patient’s death, a receipt shall be obtained from the next of kin, the resident’s guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department shall turn the funds over to the estate.

81.4(4) Safeguarding personal property. The facility shall safeguard the resident’s personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident’s suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident’s record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident’s personal effects.

c. Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person’s permanent medical record, to receive it, in which case the mail is held unopened for the resident’s conservator or relatives. Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2)”a,” and 249A.4.

441—81.5(249A) Discharge and transfer. (See paragraph 81.13(6)”c.”)
81.5(1) Notice. When a Medicaid member requests transfer or discharge, or another person requests this for the member, the administrator shall promptly notify the department. This shall be done in sufficient time to permit a social service worker or case manager to assist in the planning for the transfer or discharge.

81.5(2) Case activity report. A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

81.5(3) Plan. The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

81.5(4) Transfer records. When a resident is transferred to another facility, transfer information shall be summarized from the facility’s records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.
b. Aid to daily living information.
c. Transfer orders.
d. Nursing care plan.
e. Physician’s orders for care.
f. The resident’s personal records.
g. When applicable, the personal needs fund record.
h. Resident care review team assessment.

81.5(5) Unused client participation. When a resident leaves the facility during the month, any unused portion of the resident’s client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a,” and 249A.4.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.6(249A) Financial and statistical report and determination of payment rate. With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the Iowa Medicaid enterprise provider cost audit and rate setting unit. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report. These reports shall be based on the following rules.

81.6(1) Failure to maintain records. Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility may result in the penalties specified in subrule 81.14(1).

81.6(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statements of the facility. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

a. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

b. Costs for patient care services shall be divided into the subcategories of “direct patient care costs” and “support care costs.” Costs associated with food and dietary wages shall be included in the “support care costs” subcategory.

81.6(3) Submission of reports. All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the Iowa Medicaid enterprise provider cost audit and rate setting unit not later than the last day of the fifth calendar month after the close of the provider’s reporting year. The Iowa Veterans Home shall submit the report electronically, in a format approved by the department, no later than three months after the close of each six-month period of the
facility’s established fiscal year. The annual financial report shall coincide with the fiscal year used by
the provider to report federal income taxes for the operation unless the provider requests in writing that
a different reporting period be used. Such a request shall be submitted within 60 days after the initial
certification of a provider. The option to change the reporting period may be exercised only one time by
a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting
purposes. If a reporting period other than the tax year is established, audit trails between the periods
are required, including reconciliation statements between the provider’s records and the annual financial
report.

a. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services
are required to submit a copy of their Medicare cost report that covers their most recently completed
historical reporting period as submitted to the Medicare fiscal intermediary.

b. The submission shall include a working trial balance that corresponds to all financial data
contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa
Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general
ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to
the nursing facility in the working trial balance, an allocation method must be identified for each line,
including the statistics used in the calculation. Reports submitted without a working trial balance shall
be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph
81.6(3)“e.”

c. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy
of the compilation, review or audit, including notes, for the reporting period shall be included with the
submission of the financial and statistical report as set forth in subrule 81.6(2).

d. For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing
period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare
filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the
Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission
of its report. Notice of the extension shall be presented to the department within ten days of a decision
by Medicare.

e. A complete submission shall include all of the items identified in this subrule. Failure to submit
a complete report that meets the requirements of this rule within the stated time shall reduce payment to
75 percent of the current rate.

(1) The reduced rate shall be effective the first day of the sixth month following the provider’s fiscal
year end and shall remain in effect until the first day of the month after the delinquent report is received
by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate shall be paid for no longer than three months, after which time no further
payments will be made until the first day of the month after the delinquent report is received by the Iowa
Medicaid enterprise provider cost audit and rate setting unit.

f. When a nursing facility continues to include in the total costs an item or items which had in a
prior period been removed through an adjustment made by the department or its contractor, the contractor
shall recommend to the department that the per diem be reduced to 75 percent of the current payment
rate for the entire quarter beginning the first day of the fourth month after the facility’s fiscal year end. If
the adjustment has been contested and is still in the appeals process, the provider may include the cost,
but must include sufficient detail so that the Iowa Medicaid enterprise provider cost audit and rate setting
unit can determine if a similar adjustment is needed in the current period. The department may, after
considering the seriousness of the offense, make the reduction.

g. Nothing in this subrule relieves a facility of its obligation to immediately inform the department
that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost
report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that
funds have been incorrectly paid or when an overpayment has been detected.

h. A facility may change its fiscal year one time in any two-year period. If the facility changes its
fiscal year, the facility shall notify the Iowa Medicaid enterprise cost audit and rate setting unit 60 days
prior to the first date of the change.
81.6(4) Payment at new rate.

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below shall be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility’s Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed $94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.6(16). In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility’s Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed $94, times an inflation factor pursuant to subrule 81.6(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.6(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

b. The Medicaid payment rate for special population nursing facilities shall be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities shall be updated annually without a quarterly adjustment.

81.6(5) Accrual basis. Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.6(6) Census of Medicaid members. Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

81.6(7) Patient days. In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.6(8) Opinion of accountant. The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.6(9) Calculating patient days. When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient’s status at midnight at the end of each day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

81.6(10) Revenues. Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinency, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:
(1) Laboratory or diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and
(2) Prescription (legend) drugs.
   b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.
   c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services which are included in the medical assistance per diem will not be offset.
   d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.
   e. Laundry revenue shall be applied to laundry expense.
   f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

81.61(11) Limitation of expenses. Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.
   a. Federal and state income taxes are not allowed as reimbursable costs.
   b. Fees paid directors and nonworking officers’ salaries are not allowed as reimbursable costs.
   c. Bad debts are not an allowable expense.
   d. Charity allowances and courtesy allowances are not an allowable expense.
   e. Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal costs shall be prorated. Amounts which appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.
   (1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).
   (2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.
   (3) At the time of annual contract renewal with the Iowa department of transportation, each facility which supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation’s rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.
   (4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.
   (5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.
   (6) Travel for which a patient must pay is not an allowable expense.
   (7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.
   f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.
   g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.
   h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent,
child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility’s fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.6(3)“e.”

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) Effective July 1, 2001, the base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is $3,296 per month plus $35.16 per month per licensed bed capacity for each bed over 60, not to exceed $4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.6(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing
facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.6(11)“h”(4) to 81.6(11)“h”(7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. In the case that an owner’s or immediate relative’s time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

i. Management fees paid to a related party shall be limited on the same basis as the owner administrator’s salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. For financial and statistical reports received after March 18, 2020, the depreciation, as limited in this rule, may be included as an allowable patient cost.

(1) Limitation on calculation. Depreciation shall be calculated based on the tax cost using only the straight-line method of computation and recognizing the estimated useful life of the asset as defined in the most recent edition of the American Hospital Association Useful Life Guide.

(2) Limitation—full depreciation. Once an asset is fully depreciated, no further depreciation shall be claimed on that asset.

(3) Change of ownership. Depreciation is further limited by the limitations in subrule 81.6(12).

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) “Necessary” requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) “Proper” requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider’s qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider’s qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.
Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

For financial and statistical reports received after March 18, 2020, the following definitions, calculations, and limitations shall be used to determine allowable rent expense on a cost report.

1. Landlord’s other expenses. Landlord’s other expenses are limited to amortization, mortgage interest, property taxes unless claimed as a lessee expense, utilities paid by the landlord unless claimed as a lessee expense, property insurance, and building maintenance and repairs.

2. Reasonable rate of return. Reasonable rate of return means the historical cost of the facility in the hands of the owner when the facility first entered the Medicaid program multiplied by the 30-year Treasury bond rate as reported by the Federal Reserve Board at the date of lease inception.

3. Nonrelated party leases. When the operator of a participating facility rents from a party that is not a related party, as defined in paragraph 81.6(11)“l,” the allowable cost report rental expense shall be the lesser of:
   1. Lessor’s annual depreciation as identified in paragraph 81.6(11)“j” plus the landlord’s other expenses, plus a reasonable rate of return; or
   2. Actual rent payments.
   4. Related party leases. When the operator of a participating facility rents from a related party, as defined in paragraph 81.6(11)“l,” the allowable cost report rental expense shall be the lesser of:
      1. Lessor’s annual depreciation as identified in paragraph 81.6(11)“j” plus the landlord’s other expenses; or
      2. Actual rent payments.

Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are unallowable:

1. Any fees or portion of fees used or designated for lobbying.
2. Nonrefundable and unused retainers.
3. Fees paid by the facility for the benefit of employees.
4. Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.
   1. The costs have actually been incurred and paid,
   2. The costs are reasonable expenditures for the services obtained,
   3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and
   4. The facility prevails on the disputed issue.
p. The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36, Division II, shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.6(21) "a."

q. Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5) "d." The Iowa Medicaid program will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

r. Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the Iowa Medicaid enterprise provider cost audit and rate setting unit shall adjust each provider’s reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments shall be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

s. Penalties or fines imposed by federal, state or local agencies are not allowable expenses.

t. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

u. Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

v. Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

81.6(12) **Termination or change of owner:**

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services with at least 60 days’ prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change occurs. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the
facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

81.6(13) Amended reports. The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem summary and adjustments following a review of a financial and statistical report. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

81.6(14) Payment to new facility. The payment to a new facility shall be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.6(16) “c.” After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component shall be adjusted by the facility’s average Medicaid case-mix index pursuant to subrule 81.6(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility’s first fiscal year, rates will be established in accordance with subrule 81.6(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year.

81.6(15) Payment to new owner: An existing facility with a new owner shall continue to be reimbursed using the previous owner’s per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility’s fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year. The facility shall notify the Iowa Medicaid enterprise provider cost audit and rate setting unit of the date the facility’s fiscal year will end.

81.6(16) Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate. This subrule provides for the establishment of the modified price-based reimbursement rate. The first step in the rate calculation (paragraph “a”) determines the per diem direct care and non-direct care component costs. The second step (paragraph “b”) normalizes the per diem direct care component costs to remove cost variations associated with different levels of resident case mix. The third step (paragraph “c”) calculates the patient-day-weighted medians for the direct care and non-direct care components that are used in subsequent steps to establish rate component limits and excess payment allowances, if any. The fourth step (paragraph “d”) calculates the potential excess
payment allowance. The fifth step (paragraph “e”) calculates the reimbursement rate, including any applicable capital cost per diem instant relief add-on described in paragraph “h,” that is further subjected to the rate component limits, including any applicable enhanced non-direct care rate component limit described in paragraph “h,” in step six (paragraph “f”). The seventh step (paragraph “g”) calculates the additional reimbursement based on accountability measures available beginning July 1, 2002.

a. Calculation of per diem cost. For purposes of calculating the non-state-owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs shall be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility’s per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001, July 1, 2003, July 1, 2004, July 1, 2005, and every second year thereafter, total reported allowable costs shall be adjusted using the inflation factor specified in subrule 81.6(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state-owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or 85 percent of the licensed capacity of the facility, whichever is greater. For the reimbursement period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or 70 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.6(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility’s per diem direct care costs by the facility’s cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.6(19).

c. Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median shall be established for both the non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state-owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.6(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated. The non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are
recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.6(18).

3. For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, shall be inflated to July 1, 2004, using the inflation factor specified in subrule 81.6(18).

d. Excess payment allowance.

1. For non-state-operated nursing facilities not located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

   a. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider’s allowable normalized per patient day direct care costs pursuant to 81.6(16)“b” times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

   b. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider’s allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) “a.” In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

2. For non-state-operated nursing facilities located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

   a. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider’s allowable normalized per patient day direct care costs pursuant to paragraph 81.6(16) “b” times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

The wage index factor applied July 1, 2001, through June 30, 2002, shall be 11.46 percent. Beginning July 1, 2002, and thereafter, the wage index factor shall be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by the Centers for Medicare and Medicaid Services (CMS) each July. The geographic wage index adjustment shall not exceed $8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department’s procedures for requesting exceptions at rule 441—1.8(17A,217).

b. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider’s allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) “a.” In no case shall the excess
payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider’s normalized allowable per patient day direct care costs pursuant to paragraph 81.6(16)“b” times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider’s allowable per patient day non-direct care cost pursuant to paragraph 81.6(16)“a.” In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph “d,” not to exceed the rate component limits determined by the methodology in paragraph “f.”

(1) For non-state-owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider’s normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.6(19), plus the allowed excess payment allowance as determined by the methodology in paragraph “d.”

2. The non-direct care component is equal to the provider’s allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph “d” and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph “h.”

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities shall be the facility’s average allowable per diem costs, adjusted for inflation pursuant to subrule 81.6(18), based on the most current financial and statistical report.

f. Notwithstanding paragraphs “d” and “e,” in no instance shall a rate component exceed the rate component limit defined as follows:

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:
1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph “d” times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

3. For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:
   1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).
   2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

4. For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:
   1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).
   2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

g. Pay-for-performance program. Effective July 1, 2010, additional reimbursement based on the nursing facility pay-for-performance program is available for non-state-owned facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility’s achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the “payment period”) for which there is funding appropriated by the legislature.

   (1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types shall not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

   (2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident’s quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing facility’s achievement of multiple measures suggests that quality is an essential element in the facility’s delivery of resident care.

   (3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, “direct care staff” is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. “Direct care staff” does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

   (4) Qualifying for additional reimbursement. The Iowa Medicaid enterprise shall annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51
points. The relationship of the score achieved to additional payments is described in subparagraph (10).

Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Measurement Period</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subcategory: Person-Directed Care</td>
<td></td>
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</tr>
<tr>
<td><strong>Enhanced Dining A:</strong> The facility makes available menu options and alternative selections for all meals.</td>
<td>For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period</td>
<td>1 point</td>
<td>Self-certification</td>
</tr>
<tr>
<td><strong>Enhanced Dining B:</strong> The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.</td>
<td>For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period</td>
<td>1 point</td>
<td>Self-certification</td>
</tr>
<tr>
<td><strong>Enhanced Dining C:</strong> The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.</td>
<td>For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period</td>
<td>2 points</td>
<td>Self-certification</td>
</tr>
<tr>
<td><strong>Resident Activities A:</strong> The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.</td>
<td>For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period</td>
<td>1 point</td>
<td>Self-certification</td>
</tr>
<tr>
<td>Standard</td>
<td>Measurement Period</td>
<td>Value</td>
<td>Source</td>
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<tr>
<td>Resident Activities B:</td>
<td>For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period</td>
<td>1 point</td>
<td>Self-certification</td>
</tr>
<tr>
<td>The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.</td>
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</tr>
<tr>
<td>Resident Activities C:</td>
<td>For SFY 2010, 10/1/09 to 3/31/10; thereafter, July through March of payment period</td>
<td>2 points</td>
<td>Self-certification</td>
</tr>
<tr>
<td>The facility’s residents report that activities meet their social, emotional and spiritual needs.</td>
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<td></td>
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<tr>
<td>Resident Choice A:</td>
<td>For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period</td>
<td>1 point</td>
<td>Self-certification</td>
</tr>
<tr>
<td>The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.</td>
<td></td>
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</tr>
<tr>
<td>Resident Choice B:</td>
<td>For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period</td>
<td>1 point</td>
<td>Self-certification</td>
</tr>
<tr>
<td>The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.</td>
<td></td>
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</tr>
<tr>
<td>Consistent Staffing:</td>
<td>For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period</td>
<td>3 points</td>
<td>Self-certification</td>
</tr>
<tr>
<td>The facility has all direct care staff members caring for the same residents at least 70% of their shifts.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Accreditation:</td>
<td>For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period</td>
<td>13 points</td>
<td>Self-certification</td>
</tr>
<tr>
<td>The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.</td>
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</tbody>
</table>

**NOTE:** A facility that receives points for this measure does not receive points for any other measures in this subcategory.
### Standard

<table>
<thead>
<tr>
<th>Measurement Period</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resident/Family Satisfaction Survey:</strong> The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility. To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility’s state survey results until the next satisfaction survey is completed.</td>
<td>For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period</td>
<td>5 points</td>
</tr>
<tr>
<td><strong>Long-Term Care Ombudsman:</strong> The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.</td>
<td>Calendar year ending December 31 of the payment period</td>
<td>5 points if resolution 70% to 74% 7 points if resolution 75% or greater</td>
</tr>
<tr>
<td><strong>Deficiency-Free Survey:</strong> The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations. If a facility’s only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to July 30, 1999, the facility shall be deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.</td>
<td>Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations</td>
<td>10 points</td>
</tr>
<tr>
<td><strong>Regulatory Compliance with Survey:</strong> No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.</td>
<td>Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations</td>
<td>5 points <strong>NOTE:</strong> A facility that receives points for a deficiency-free survey does not receive points for this measure.</td>
</tr>
</tbody>
</table>

(6) **Domain 2: Quality of care.**
<table>
<thead>
<tr>
<th>Standard</th>
<th>Measurement Period</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Hours Provided:</td>
<td>Facility fiscal year ending on or before December 31 of the payment period</td>
<td>5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation</td>
<td>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit. The facility cost report period case-mix index shall be used to normalize nursing hours.</td>
</tr>
<tr>
<td>Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.</td>
<td>Facility fiscal year ending on or before December 31 of the payment period</td>
<td>10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation</td>
<td>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit</td>
</tr>
<tr>
<td>Employee Turnover:</td>
<td>Facility fiscal year ending on or before December 31 of the payment period</td>
<td>5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55%</td>
<td>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit</td>
</tr>
<tr>
<td>The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.</td>
<td>Facility fiscal year ending on or before December 31 of the payment period</td>
<td>10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%</td>
<td>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit</td>
</tr>
<tr>
<td>Staff Education, Training and Development:</td>
<td>Calendar year ending December 31 of the payment period</td>
<td>5 points</td>
<td>Self-certification</td>
</tr>
<tr>
<td>The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.</td>
<td>Calendar year ending December 31 of the payment period</td>
<td>5 points</td>
<td>Self-certification</td>
</tr>
<tr>
<td>Staff Satisfaction Survey:</td>
<td>For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period</td>
<td>5 points</td>
<td>Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results</td>
</tr>
</tbody>
</table>
### Standard Measurement Period Value Source

#### Subcategory: Nationally Reported Quality Measures

**High-Risk Pressure Ulcer:**
The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.

<table>
<thead>
<tr>
<th>Measurement Period</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-month period ending September 30 of the payment period</td>
<td>3 points if one-half to one standard deviation below the mean percentage of occurrences</td>
<td>IME medical services unit report based on MDS data as applied to the nationally reported quality measures.</td>
</tr>
<tr>
<td></td>
<td>5 points if one standard deviation or more below the mean percentage of occurrences</td>
<td></td>
</tr>
</tbody>
</table>

**Physical Restraints:**
The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.

<table>
<thead>
<tr>
<th>Measurement Period</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-month period ending September 30 of the payment period</td>
<td>5 points</td>
<td>IME medical services unit report based on MDS data as reported by CMS</td>
</tr>
</tbody>
</table>

**Chronic Care Pain:**
The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.

<table>
<thead>
<tr>
<th>Measurement Period</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-month period ending September 30 of the payment period</td>
<td>3 points if one-half to one standard deviation below the mean rate of occurrences</td>
<td>IME medical services unit report based on MDS data as reported by CMS</td>
</tr>
<tr>
<td></td>
<td>5 points if one standard deviation or more below the mean rate of occurrences</td>
<td></td>
</tr>
</tbody>
</table>

**High Achievement of Nationally Reported Quality Measures:**
The facility received at least 9 points from a combination of the measures listed in this subcategory.

<table>
<thead>
<tr>
<th>Measurement Period</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-month period ending September 30 of the payment period</td>
<td>2 points if the facility receives 9 to 12 points in the subcategory of nationally reported quality measures</td>
<td>IME medical services unit report based on MDS data as reported by CMS</td>
</tr>
<tr>
<td></td>
<td>4 points if the facility receives 13 to 15 points in this subcategory</td>
<td></td>
</tr>
</tbody>
</table>

(7) **Domain 3: Access.**

#### Standard Measurement Period Value Source

**Special Licensure Classification:**
The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).

<table>
<thead>
<tr>
<th>Measurement Period</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status on December 31 of the payment period</td>
<td>4 points</td>
<td>DIA list of facilities meeting the standard</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Standard</th>
<th>Measurement Period</th>
<th>Value</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.</td>
<td>Facility fiscal year ending on or before December 31 of the payment period</td>
<td>3 points if Medicaid utilization is more than the median plus 10%</td>
<td>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 points if Medicaid utilization is more than the median plus 20%</td>
<td></td>
</tr>
<tr>
<td>(8) Domain 4: Efficiency.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Occupancy Rate: The facility has an occupancy rate at or above 95%. “Occupancy rate” is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.</td>
<td>Facility fiscal year ending on or before December 31 of the payment period</td>
<td>4 points</td>
<td>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit</td>
</tr>
<tr>
<td>Low Administrative Costs: The facility’s percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.</td>
<td>Facility fiscal year ending on or before December 31 of the payment period</td>
<td>3 points if administrative costs percentage is less than the mean less one-half standard deviation</td>
<td>Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 points if administrative costs percentage is less than the mean less one standard deviation</td>
<td></td>
</tr>
</tbody>
</table>

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data shall be drawn from a report submitted by the facility to IME. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to IME on Form 470-3891, Nursing Facility Opinion Survey Transmittal. The department shall request required source reports from the long-term care ombudsman and the department of inspections and appeals (DIA).

(10) Calculation of potential add-on payment. The number of points awarded shall be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):
<table>
<thead>
<tr>
<th>Score</th>
<th>Amount of Add-on Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-50 points</td>
<td>No additional reimbursement</td>
</tr>
<tr>
<td>51-60 points</td>
<td>1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)</td>
</tr>
<tr>
<td>61-70 points</td>
<td>2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)</td>
</tr>
<tr>
<td>71-80 points</td>
<td>3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)</td>
</tr>
<tr>
<td>81-90 points</td>
<td>4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)</td>
</tr>
<tr>
<td>91-100 points</td>
<td>5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)</td>
</tr>
</tbody>
</table>

(11) Monitoring for reduction or forfeiture of reimbursement. The department shall request the department of inspections and appeals to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.
2. A facility’s add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.
3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program shall be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the Iowa Medicaid enterprise shall:

1. Retroactively adjust each qualifying facility’s quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.6(16)“g” ; and
2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and
2. Used in a manner that improves and enhances quality of care for residents.
(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, to report the use of any additional payments received for the nursing facility pay-for-performance program. Form 470-4829 is due to the department each year by May 1, beginning May 1, 2011. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department shall publish the results of the nursing facility pay-for-performance program annually.

h. Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the Centers for Medicare and Medicaid Services (CMS) and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph "f."

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph "f". The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or
2. Development of home- and community-based waiver program services.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent for the two-month period before the request for additional reimbursement is submitted. Medicaid utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total licensed bed capacity as reported on the facility’s most current financial and statistical report.

2. The facility meets the accountability measure criteria set forth in paragraph “g.” subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.

2. Services shall be provided on the direct site of the facility but not as a nursing facility service.

3. Services shall meet all federal and state requirements for Medicaid reimbursement.

4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the Iowa Medicaid Enterprise, Provider
Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility’s request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. The period during which the add-on is requested (no more than two years).

4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)

5. A copy of the facility’s most current depreciation schedule which clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.

6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:
   - The estimated date the assets will be placed into service;
   - The total estimated depreciable value of the assets;
   - The estimated useful life of the assets based upon existing Medicaid and Medicare provisions; and
   - The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.

7. The facility’s estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days shall be determined using the most current submitted financial and statistical report.

8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

(7) Content of request for enhanced limit. A facility’s request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.
(8) Content of request for preliminary evaluation. A facility’s request for a preliminary evaluation of a proposed project shall include:

1. The estimated completion date of the project.
2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.
3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).
4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).

(9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility’s estimated annual total patient days.

1. Effective December 1, 2009, total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 85 percent of the facility’s estimated licensed capacity. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. A reconciliation between the estimated amounts and actual amounts shall be completed as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph ‘f.’

(11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the facility’s submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid Enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility’s submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. Effective December 1, 2009, for purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility’s actual licensed bed capacity during the period in which the add-on was paid. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses
for non-state-owned facilities shall be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph “f.” The facility’s quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit shall be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or
2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval shall be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the Iowa Medicaid enterprise is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or
2. The facility does not make reasonable progress on any plans required for initial qualification; or
3. The facility’s medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership shall continue under the new owner. Future reimbursement rates shall be determined pursuant to subrules 81.6(15) and 81.6(16).

81.6(17) Cost report documentation. All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility’s fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility’s fiscal year and the midpoint of the facility’s fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.

b. The starting and average hourly wage for each class of employees for the period of the report.

c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

81.6(18) Inflation factor. The department shall consider an inflation factor in determining the reimbursement rate. The inflation factor shall be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in
the latest available quarterly publication prior to the July 1 rate setting shall be used to determine the inflation factor.

**81.6(19) Case-mix index calculation.**

a. The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.13(9). Standard Version 5.12b case-mix indices developed by CMS shall be the basis for calculating the average case-mix index and shall be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.6(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident’s most current assessment available on the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph “a.” From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors shall be excluded from both average case-mix index calculations.

**81.6(20) Medicare crossover claims for nursing facility services.**

a. Definitions. For purposes of this subrule:

“Crossover claim” means a claim for Medicaid payment for Medicare-covered nursing facility services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“Medicaid-allowed amount” means the Medicaid reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

“Medicaid reimbursement” includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

“Medicare payment amount” means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Crossover claims. Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

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

2. If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim is the lesser of:
   a. The Medicaid-allowed amount minus the Medicare payment amount; or
   b. The Medicare coinsurance and deductible amounts applicable to the claim.

**81.6(21) Nursing facility quality assurance payments.**

a. Quality assurance assessment pass-through. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance assessment pass-through shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through shall equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).
b. Quality assurance assessment rate add-on. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance add-on of $15 per patient day shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. Use of the pass-through and add-on. As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers determined pursuant to 2009 Iowa Acts, Senate File 476.

(2) No less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to 2009 Iowa Acts, Senate File 476.

d. Effective date. Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, has been approved by the federal Centers for Medicare and Medicaid Services, none of the nursing facility rate-setting methodologies of this subrule shall become effective.

e. End date. If the federal Centers for Medicare and Medicaid Services determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule shall be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department shall:

(1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;

(2) Recompute Medicaid payments due based on the recalculated Medicaid rates;

(3) Recoup any previous overpayments; and

(4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16 and chapters 249K and 249L.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8445B, IAB 1/13/10, effective 1/11/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 4428C, IAB 5/8/19, effective 7/1/19; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 4900C, IAB 2/12/20, effective 3/18/20; ARC 6226C, IAB 3/9/22, effective 5/1/22]

441—81.7(249A) Continued review.

81.7(1) Level of care. The IME medical services unit shall review Medicaid members’ need for continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1). For all members enrolled with a managed care organization, the managed care organization shall review a Medicaid member’s need for continued care in a nursing facility at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

81.7(2) PASRR. As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident’s condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department’s contractor for PASRR evaluations. For purposes of this subrule, “significant change in a resident’s condition” means any admission or readmission to the facility
immediately following an inpatient psychiatric hospitalization or any change that is likely to impact
the resident's treatment needs related to a mental illness or intellectual disability. The evaluation shall
determine:
a. Whether nursing facility care or skilled nursing care is medically necessary and appropriate for
the resident under 441—subrules 79.9(1) and 79.9(2);
b. Whether nursing facility services continue to be appropriate for the resident, as opposed to care
in a more specialized facility or in a community-based setting; and
c. Whether the resident needs specialized services for mental illness or intellectual disability, as
described in paragraph 81.3(3)’h.’

This rule is intended to implement Iowa Code sections 249A.2(1), 249A.3(3), and 249A.4.
[ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective
1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.8 Reserved.

441—81.9(249A) Records.

81.9(1) Content. The facility shall as a minimum maintain the following records:
a. All records required by the department of public health and the department of inspections and
appeals.
b. Records of all treatments, drugs, and services for which vendors’ payments have been made
or are to be made under the medical assistance program, including the authority for and the date of
administration of the treatment, drugs, or services.
c. Documentation in each resident’s records which will enable the department to verify that each
charge is due and proper prior to payment.
d. Financial records maintained in the standard, specified form including the facility’s most recent
audited cost report.
e. All other records as may be found necessary by the department in determining compliance with
any federal or state law or rule or regulation promulgated by the United States Department of Health and
Human Services or by the department.
f. Census records to include the date, number of residents at the beginning of each day, names of
residents admitted, and names of residents discharged.
   (1) Census information shall be provided for all residents of the facility.
   (2) Census figures for each type of care shall be totaled monthly to indicate the number admitted,
the number discharged, and the number of patient days.
   (3) Failure to maintain acceptable census records shall result in the per diem rate being computed
on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing
care which have not been properly accounted for.
g. Resident accounts.
h. In-service education program records.
i. Inspection reports pertaining to conformity with federal, state and local laws.
j. Residents’ personal records.
k. Residents’ medical records.
l. Disaster preparedness reports.

81.9(2) Retention. Records identified in subrule 81.9(1) shall be retained in the facility for a
minimum of five years or until an audit is performed on those records, whichever is longer.

81.9(3) Change of owner. All records shall be retained within the facility upon change of ownership.
This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)”a.”

441—81.10(249A) Payment procedures.

81.10(1) Method of payment. Except for Medicaid accountability measures payment established
in paragraph 81.6(16)”g.” facilities shall be reimbursed under a modified price-based vendor payment
program. A per diem rate shall be established based on information submitted according to rule
81.10(2) Authorization of payment. The department shall authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

81.10(3) Reserved.

81.10(4) Periods authorized for payment.
   a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.
   b. Payment will be authorized as long as the resident is certified as needing care in a nursing facility.
   c. Payment will be approved for the day of admission but not the day of discharge or death.
   d. Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident’s physician in the plan of care that additional days would be rehabilitative.
   e. Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.
   f. Payment for periods when residents are absent for a visit, vacation, or hospitalization shall be made at zero percent of the nursing facility’s rate, except for special population facilities and state-operated nursing facilities, which shall be paid for such periods at 42 percent of the facility’s rate.
   g. Payment for residents determined by utilization review to require the residential level of care shall be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.
   h. Ventilator patients.
      (1) Definition. For purposes of this paragraph only, “ventilator patients” means Medicaid-eligible patients who, as determined by the quality improvement organization, require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care.
      (2) Reimbursement. In-state nursing facilities shall receive reimbursement for care of ventilator patients equal to the sum of the Medicare-certified hospital-based nursing facility rate plus the Medicare-certified hospital-based nursing facility non-direct care rate component as defined in subparagraph 81.6(16) “f” (3). Facilities may continue to receive this reimbursement at this rate for 30 days after a ventilator patient is weaned from a ventilator if, during the 30 days, the patient continues to reside in the facility and continues to meet skilled care criteria.
        i. Payment for residents of a special population facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness will be made only when the resident is aged 65 or over. If a resident under the age of 65 is admitted with a payment source other than Medicaid, the facility shall notify the resident, or when applicable the resident’s guardian or legal representative, that Iowa Medicaid may neither make payment to the facility nor make payment for any other services rendered by any provider while the person resides in the facility, until the resident attains the age of 65.
        j. Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:
           (1) The wrong surgical or other invasive procedure is performed on a resident; or
           (2) A surgical or other invasive procedure is performed on the wrong body part; or
(3) A surgical or other invasive procedure is performed on the wrong resident.

81.10(5) Supplementation. Only the amount of client participation may be billed to the resident for the cost of care, and the facility must accept the combination of client participation and payment made through the Iowa Medicaid program as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services, but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to 441—paragraph 78.10(2)“d,” medical supplies except for those listed in 441—paragraph 78.10(4)“b,” oxygen except under circumstances specified in 441—paragraph 78.10(2)“a,” and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician.

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

b. The facility shall arrange for nonemergency transportation for members to receive necessary medical services outside the facility.

(1) If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation within 30 miles of the facility (one way).

(2) For medically necessary transportation beyond 30 miles from the facility (one way), when no family member, friend, or volunteer is available to provide the transportation at no charge, the facility shall arrange for transportation through the broker designated by the department, with the cost to be paid by the broker pursuant to rule 441—78.13(249A).

c. The Medicaid program will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by providers enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

(5) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)“a”(4).

d. Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—subrule 78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances that belong to the resident.

(5) Transportation to receive medical services beyond 30 miles from the facility (one way), through the broker designated by the department pursuant to a contract between the department and the broker.

(6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident’s family, or friends may pay to hold the resident’s bed in cases where a resident who is not discharged from the facility is absent overnight. When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.
(2) Payments made by the resident’s family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. Supplementation for provision of a private room is not permitted for any time period during which the private room is therapeutically required pursuant to 42 CFR § 483.10(c)(8)(ii).

2. Supplementation for provision of a private room is not permitted for a calendar month if no room other than the private room was available as of the first day of the month or as of the resident’s subsequent initial occupation of the private room.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility’s occupancy rate was less than 50 percent as of the first day of the month or as of the resident’s subsequent initial occupation of the private room.

4. Supplementation for provision of a private room is not permitted if the nursing facility only provides one type of room or all private rooms.

5. If a nursing facility provides for supplementation for provision of a private room, the facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private-pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources for a calendar month shall not be greater than the aggregate average private room rate during that month for the type of rooms covered under the medical assistance program for which the resident would be eligible.

6. If a nursing facility provides for supplementation for provision of a private room, the facility shall inform all residents, prospective residents, and their legal representatives of the following:
   - That if the resident desires a private room, the resident or resident’s family may provide supplementation by directly paying the facility the amount of supplementation;
   - The nursing facility’s policy if a resident residing in a private room converts from private pay to payment under the medical assistance program but the resident or resident’s family is not willing or able to pay supplementation for the private room;
   - The private rooms for which supplementation is available, including a description and identification of such rooms; and
   - The process for an individual to take legal responsibility for providing supplementation, including identification of the individual and the extent of the legal responsibility.

7. For a resident for whom the nursing facility receives supplementation, the nursing facility shall indicate in the resident’s record all of the following:
   - A description and identification of the private room for which the nursing facility is receiving supplementation;
   - The identity of the individual making the supplemental payments;
   - The private-pay charge for the private room for which the nursing facility is receiving supplementation; and
   - The total charge to the resident for the private room for which the nursing facility is receiving supplementation, the portion of the total charge reimbursed under the medical assistance program, and the portion of the total charge reimbursed through supplementation.

8. Supplementation pursuant to this subparagraph shall not be required as a precondition of admission, expedited admission, or continued stay in a facility.

9. The nursing facility shall ensure that all appropriate care is provided to all residents notwithstanding the applicability or availability of supplementation.

10. A private room for which supplementation is required shall be retained for the resident consistent with bed-hold policies.
11. A nursing facility that utilizes the supplementation pursuant to this subparagraph during any calendar year shall report to the department annually by January 15 the following information for the preceding calendar year:

- The total number of nursing facility beds available at the nursing facility, the number of such beds available in private rooms, and the number of such beds available in other types of rooms.
- The average occupancy rate of the facility on a monthly basis.
- The total number of residents for whom supplementation was utilized.
- The average private pay charge for a private room in the nursing facility.
- For each resident for whom supplementation was utilized, the total charge to the resident for the private room, the portion of the total charge reimbursed under the Medicaid program, and the total charge reimbursed through supplementation.

f. Any medical equipment, supplies, appliances, or devices, personal care items, drugs, or other items of personal property that are paid for directly by the Medicaid program or are paid for by the resident or the resident’s family, on a nonrental basis, are the personal property of the resident.

g. The facility shall not charge a resident for days that are not covered under Medicaid due to a provider-preventable condition pursuant to paragraph 81.10(4)“j” and shall not discharge a resident due to nonpayment for such days.

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

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 9099B, IAB 8/11/10, effective 9/15/10; ARC 9714C, IAB 5/1/13, effective 7/1/13; ARC 1151C, IAB 10/30/13, effective 1/1/14; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 4900C, IAB 2/12/20, effective 3/18/20]

441—81.11(249A) Billing procedures.

81.11(1) Claims. Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims must be submitted electronically through Iowa Medicaid’s electronic clearinghouse. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system. Adjustments to submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise. A request for an adjustment to a paid claim must be received by the Iowa Medicaid enterprise within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

81.11(2) Reserved.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)“a.”

[ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.12(249A) Closing of facility. When a facility is planning on closing, the department and the department’s contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the resident’s managed care organization or by the IME medical services unit for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2)“a.”

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.13(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

81.13(1) Procedures for establishing health care facilities as Medicaid facilities. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication “State Operations Manual.”

a. The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

c. The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.
d. The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.

e. The Iowa Medicaid enterprise provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.

f. Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.

g. The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

h. The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.

i. The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

j. When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

**81.13(2) Medicaid provider agreements.** The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication “Providers Certification State Operations Manual.” The effective date of a provider agreement may not be earlier than the date of certification.

a. to d. Reserved.

e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

**81.13(3) Distinct part requirement.** All facilities which provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

a. The distinct part shall meet the following conditions:

1. The distinct part shall meet all requirements for a nursing facility.

2. The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections and appeals.

3. The appropriate personnel shall be assigned to the identifiable unit and shall work regularly therein. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

4. The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

5. When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident’s medical chart and stands as a continuing order unless the circumstances requiring the exception change.

**81.13(4) Civil rights.** The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 in all areas of administration including admissions, records, services and physical facilities,
room assignments and transfers, attending physicians’ privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

81.13(5) Resident rights. The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident, including each of the following rights:

a. Exercise of rights.
   (1) The resident has the right to exercise rights as a resident of the facility and as a citizen of the United States.
   (2) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.
   (3) In the case of a resident adjudged incompetent under the laws of a state, by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident’s behalf.
   (4) In the case of a resident who has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident’s rights to the extent provided by state law.

b. Notice of rights and services.
   (1) The facility shall inform the resident, both orally and in writing in a language that the resident understands, of the resident’s rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility shall also provide the resident with the pamphlet “Medicaid for People in Nursing Homes and Other Care Facilities,” Comm. 52. This notification shall be made prior to or upon admission and during the resident’s stay. Receipt of this information, and any amendments to it, must be acknowledged in writing.
   (2) The resident or the resident’s legal representative has the right, upon an oral or written request, to access all records pertaining to the resident including clinical records within 24 hours (excluding weekends and holidays); and after receipt of the records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days’ advance notice to the facility.
   (3) The resident has the right to be fully informed in language that the resident can understand of the resident’s total health status, including, but not limited to, medical condition.
   (4) The resident has the right to refuse treatment and to refuse to participate in experimental research.
   (5) The facility shall:
      1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of the items and services that are included in nursing facility services under the state plan and for which the resident may not be charged and of those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.
      2. Inform each resident when changes are made to the items and services specified in number “1” of this subparagraph.
   (6) The facility shall inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility’s per diem rate.
   (7) The facility shall furnish a written description of legal rights which includes:
      1. A description of the manner of protecting personal funds.
      2. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple’s nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse’s medical care in the resident’s process of spending down to Medicaid eligibility levels.
3. A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

4. A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility.

   (8) The facility shall inform each resident of the name, specialty and way of contacting the physician responsible for the resident’s care.

   (9) The facility shall prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by these benefits.

   (10) Notification of changes.

   1. A facility shall immediately inform the resident, consult with the resident’s physician, and, if known, notify the resident’s legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident’s physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

   2. The facility shall also promptly notify the resident and, if known, the resident’s legal representative or interested family member when there is a change in room or roommate assignment or a change in resident rights under federal or state law or regulations.

   3. The facility shall record and periodically update the address and telephone number of the resident’s legal representative or interested family member.

   c. Protection of resident funds.

   (1) The resident has the right to manage the resident’s financial affairs and the facility may not require residents to deposit their personal funds with the facility.

   (2) Management of personal funds. Upon written authorization of a resident, the facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified in subparagraphs (3) to (8) of this paragraph.

   (3) Deposit of funds. The facility shall deposit any residents’ personal funds in excess of $50 in an interest-bearing account that is separate from any of the facility’s operating accounts, and that credits all interest earned on the resident’s funds to that account. In pooled accounts, there must be a separate accounting for each resident’s share.

   The facility shall maintain a resident’s personal funds that do not exceed $50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.

   (4) Accounting and records. The facility shall establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf.

   1. The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

   2. The individual financial record shall be available through quarterly statements and on request to the resident or the resident’s legal representative.

   (5) Notice of certain balances. The facility shall notify each resident that receives Medicaid benefits:

   1. When the amount in the resident’s account reaches $200 less than the SSI resource limit for one person.

   2. That, if the amount in the account, in addition to the value of the resident’s other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.
(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident’s funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident’s estate.

(7) Assurance of financial security. The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the department of inspections and appeals and the department of human services, to ensure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

d. **Free choice.** The resident has the right to:

   (1) Choose a personal attending physician.

   (2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident’s well-being.

   (3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

e. **Privacy and confidentiality.** The resident has the right to personal privacy and confidentiality of personal and clinical records.

   (1) Personal privacy includes accommodations, medical treatment, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

   (2) The facility must respect the resident’s right to personal privacy, including the right to privacy in the resident’s oral (that is, spoken or sign language), written, and electronic communications.

   (3) Except as provided in subparagraph (4) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

   (4) The resident’s right to refuse release of personal and clinical records does not apply to the following:

      1. The release of personal and clinical records to a health care institution to which the resident is transferred; or

      2. A record release that is required by law.

f. **Grievances.** A resident has the right to:

   (1) Voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.

   (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

g. **Examination of survey results.** A resident has the right to:

   (1) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability.

   (2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

h. **Work.** The resident has the right to:

   (1) Refuse to perform services for the facility.

   (2) Perform services for the facility if the resident chooses, when:

      1. The facility has documented the need or desire for work in the plan of care.

      2. The plan specifies the nature of the services performed and whether the services are voluntary or paid.

   3. Compensation for paid services is at or above prevailing rates.

   4. The resident agrees to the work arrangement described in the plan of care.
individuals.

i. Mail. The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident, whether delivered by a postal service or by other means, including the right to:
   (1) Privacy of such communications consistent with this section; and
   (2) Access to stationary, postage, and writing implements at the resident’s own expense.

j. Access and visitation rights.
   (1) The resident has the right and the facility shall provide immediate access to any resident by the following:
      1. Any representative of the secretary of the Department of Health and Human Services.
      2. Any representative of the state.
      3. The resident’s individual physician.
      4. The state long-term care ombudsman.
      5. The agency responsible for the protection and advocacy system for developmentally disabled individuals.
      6. The agency responsible for the protection and advocacy system for mentally ill individuals.
      7. Immediate family or other relatives of the resident subject to the resident’s right to deny or withdraw consent at any time.
      8. Others who are visiting with the consent of the resident subject to reasonable restrictions and to the resident’s right to deny or withdraw consent at any time.
      (2) The facility shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident’s right to deny or withdraw consent at any time.
      (3) The facility shall allow representatives of the state ombudsman to examine a resident’s clinical records with the permission of the resident or the resident’s legal representative, and consistent with state law.

k. Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

l. Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

m. Married couples. The resident has the right to share a room with the resident’s spouse when married residents live in the same facility and both spouses consent to the arrangement.

n. Self-administration of drugs. An individual resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe.

o. Refusal of certain transfers.
   (1) A person has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a skilled nursing facility from the distinct part of the institution that is a skilled nursing facility to a part of the institution that is not a skilled nursing facility or, if a resident of a nursing facility, from the distinct part of the institution that is a nursing facility to a distinct part of the institution that is a skilled nursing facility.
   (2) A resident’s exercise of the right to refuse transfer under subparagraph (1) does not affect the resident’s eligibility or entitlement to Medicare or Medicaid benefits.

p. Advance directives.
   (1) The nursing facility, at the time of admission, shall provide written information to each resident which explains the resident’s rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives and the nursing facility’s policies regarding the implementation of these rights.
   (2) The nursing facility shall document in the resident’s medical record whether or not the resident has executed an advance directive.
   (3) The nursing facility shall not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive.
(4) The nursing facility shall ensure compliance with requirements of state law regarding advance directives.

(5) The nursing facility shall provide for education for staff and the community on issues concerning advance directives.

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

q. Electronic communication. The resident has the right to have reasonable access to and privacy in the resident’s use of electronic communications, including, but not limited to, email and video communications, and for Internet research:

(1) If accessible to the facility;
(2) At the resident’s expense, if any additional expense is incurred by the facility to provide such access to the resident; and
(3) To the extent that such use may comply with state and federal law.

81.13(6) Admission, transfer and discharge rights.

a. Transfer and discharge.

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility.
2. The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility.
3. The safety of persons in the facility is endangered.
4. The health of persons in the facility would otherwise be endangered.
5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.
6. The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (2), numbers 1 through 5 above, the resident’s clinical record shall be documented. The documentation shall be made by:

1. The resident’s physician when transfer or discharge is necessary under subparagraph (2), number 1 or 2.
2. A physician when transfer or discharge is necessary under subparagraph (2), number 4.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:

1. Notify the resident, the resident’s case manager for those residents enrolled with a managed care organization and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
2. Record the reasons in the resident’s clinical record.
3. Include in the notice the items in subparagraph (6) below.

(5) Timing of the notice. The notice of transfer or discharge shall be made by the facility at least 30 days before the resident is transferred or discharged except that notice shall be made as soon as practicable before transfer or discharge when:

1. The safety of persons in the facility would be endangered.
2. The health of persons in the facility would be endangered.
3. The resident’s health improves sufficiently to allow a more immediate transfer or discharge.
4. An immediate transfer or discharge is required by the resident’s urgent medical needs.
5. A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice shall including the following:
1. The reason for transfer or discharge.
2. The effective date of transfer or discharge.
3. The location to which the resident is transferred or discharged.
4. A statement that the resident has the right to appeal the action to the department.
5. The name, address, and telephone number of the state long-term care ombudsman.
6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals for residents with developmental disabilities.
7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals for residents who are mentally ill.

(7) Orientation for transfer or discharge. A facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

b. Notice of bed-hold policy and readmission.

(1) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility shall provide written information to the resident and a family member or legal representative that specifies:
   1. The duration of the bed-hold policy under the state plan during which the resident is permitted to return and resume residence in the facility.
   2. The facility’s policies regarding bed-hold periods, which shall be consistent with subparagraph (3) below, permitting a resident to return.

(2) Notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility shall provide written notice to the resident and a family member or legal representative, which specifies the duration of the bed-hold policy described in subparagraph (1) above.

(3) Permitting resident to return to facility. A nursing facility shall establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

c. Equal access to quality care.

(1) A facility shall establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all persons regardless of source of payment.

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in 81.13(1)“a”(5).

(3) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

d. Admissions policy.

(1) The facility shall not require residents or potential residents to:
   1. Waive their rights to Medicare or Medicaid; or
   2. Give oral or written assurance that they are not eligible for, or will not apply for, Medicare or Medicaid benefits. However, a continuing care retirement community or a life care community that is licensed, registered, certified, or the equivalent by the state, including a nursing facility that is part of such a community, may require in its contract for admission that before a resident applies for medical assistance, the resources that the resident declared for the purposes of admission must be spent on the resident’s care, subject to 441—subrule 75.5(3), 441—paragraph 75.5(4)“a,” and 441—subrule 75.16(2).

(2) The facility shall not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require a person who has legal access to a resident’s income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident’s income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money,
donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However:

1. A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the state plan as included in the term “nursing facility services” so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident’s admission or continued stay on the request for and receipt of these additional services.

2. A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

4. States or political subdivisions may apply stricter admission standards under state or local laws than are specified in these rules, to prohibit discrimination against persons entitled to Medicaid.

81.13(7) Resident behavior and facility practices.

a. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident’s medical symptoms.

b. Abuse. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

c. Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

*(1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

*See Objection filed 8/25/92 published herein at end of 441—Chapter 81.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections and appeals) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator’s designated representative or to other officials (including the department of inspections and appeals) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

81.13(8) Quality of life. A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life.

a. Dignity. The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of the resident’s individuality.

b. Self-determination and participation. The resident has the right to:

(1) Choose activities, schedules, and health care consistent with the resident’s interests, assessments and plans of care.

(2) Interact with members of the community both inside and outside the facility.

(3) Make choices about aspects of life in the facility that are significant to the resident.

c. Participation in resident and family groups.

(1) A resident has the right to organize and participate in resident groups in the facility.
(2) A resident’s family has the right to meet in the facility with the families of other residents in the facility.

(3) The facility shall provide a resident or family group, if one exists, with private space.

(4) Staff or visitors may attend meetings at the group’s invitation.

(5) The facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(6) When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

d. Participation in other activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

e. Accommodation of needs. A resident has the right to:

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

(2) Receive notice before the resident’s room or roommate in the facility is changed.

f. Activities.

(1) The facility shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program shall be directed by a qualified professional who meets one of the following criteria:

1. Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.

2. Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting.

3. Is a qualified occupational therapist or occupational therapy assistant.

4. Has completed a training course approved by the state.

g. Social services.

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is a person who meets both of the following criteria:

1. A bachelor’s degree in social work or a bachelor’s degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling and psychology.

2. One year of supervised social work experience in a health care setting working directly with individuals.

h. Environment. The facility shall provide:

(1) A safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

(3) Clean bed and bath linens that are in good condition.

(4) Private closet space in each resident room.

(5) Adequate and comfortable lighting levels in all areas.

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, shall maintain a temperature range of 71 to 81 degrees Fahrenheit.

(7) For the maintenance of comfortable sound levels.

81.13(9) Resident assessment. The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional ability.
a. Admission orders. At the time each resident is admitted, the facility shall have physician orders for the resident’s immediate care.

b. Comprehensive assessments.

1. The facility shall make a comprehensive assessment of a resident’s needs which is based on the minimum data set (MDS) specified by the department of inspections and appeals, which describes the resident’s capability to perform daily life functions and significant impairments in functional capacity.

2. The assessment process shall include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. The comprehensive assessment shall include at least the following information:
   1. Identification and demographic information.
   2. Customary routine.
   5. Vision.
   6. Mood and behavior patterns.
   7. Psychosocial well-being.
   8. Physical functioning and structural problems.
   10. Disease diagnoses and health conditions.
   11. Dental and nutritional status.
   12. Skin condition.
   15. Special treatments and procedures.
   16. Discharge potential.
   17. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
   18. Documentation of participation in assessment.
   19. Additional specification relating to resident status as required in Section S of the MDS.

3. Frequency. Assessments shall be conducted:
   1. Within 14 calendar days after admission or readmission, excluding readmissions in which there is no significant change in the resident’s physical or mental condition. “Readmission” means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.
   2. Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident’s physical or mental condition. A “significant change” means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and that requires either interdisciplinary review, revision of the care plan, or both.
   3. In no case less often than once every 12 months.

4. Review of assessments. The facility shall examine each resident no less than once every three months, and as appropriate, revise the resident’s assessment to ensure the continued accuracy of the assessment.

5. Maintenance and use. A facility shall maintain all resident assessments completed within the previous 15 months in the resident’s active record and use the results to develop, review and revise the resident’s comprehensive plan of care.

6. Coordination. The facility shall coordinate assessments with any state-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.

7. Automated data processing requirement.

   1. Entering data. Within seven days after a facility completes a resident’s assessment, a facility shall enter the following information for the resident into a computerized format that meets the specifications defined in numbered paragraphs “2” and “4” below.
● Admission assessment.
● Annual assessment updates.
● Significant change in status assessments.
● Quarterly review assessments.
● A subset of items upon a resident’s transfer, reentry, discharge, and death.
● Background (face sheet) information, if there is no admission assessment.

2. Transmitting data. Within seven days after a facility completes a resident’s assessment, a facility shall be capable of transmitting to the state each resident’s assessment information contained in the MDS in a format that conforms to standard record layouts and data dictionaries and that passes edits that ensure accurate and consistent coding of the MDS data as defined by the Centers for Medicare and Medicaid Services (CMS) and the department of human services or the department of inspections and appeals.

3. Monthly transmittal requirements. On at least a monthly basis, a facility shall input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month, including the following:
● Admission assessment.
● Annual assessment.
● Significant correction of prior full assessment.
● Significant correction of prior quarterly assessment.
● Quarterly review.
● A subset of items upon a resident’s transfer, reentry, discharge, and death.
● Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment.

4. The facility must transmit MDS data in the format specified by CMS.

(8) Resident-identifiable information. A facility shall not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

c. Accuracy of assessments. The assessment shall accurately reflect the resident’s status.

(1) Coordination. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals. Each assessment shall be conducted or coordinated by a registered nurse.

(2) Certification. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment. A registered nurse shall sign and certify that the assessment is completed.

(3) Penalty for falsification. An individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

(4) Use of independent assessors. If the department of human services or the department of inspections and appeals determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under subparagraph (3) above, the department of human services or the department of inspections and appeals may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department of human services or the department of inspections and appeals for a period specified by the agency.

d. Comprehensive care plans.

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan shall describe the following:
1. The services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under subrule 81.13(10).

2. Any services that would otherwise be required under subrule 81.13(10), but are not provided due to the resident’s exercise of rights under subrule 81.13(5), including the right to refuse treatment under subrule 81.13(5), paragraph “b,” subparagraph (4).

(2) A comprehensive care plan shall be developed within seven days after completion of the comprehensive assessment by an interdisciplinary team and with the participation of the resident, the resident’s case manager as appropriate and as allowed by the resident for those residents enrolled with a managed care organization, and the resident’s family or legal representative to the extent practicable, and shall be periodically reviewed and revised by a team of qualified persons after each assessment.

The interdisciplinary team shall include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident’s needs.

(3) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with each resident’s written plan of care.

  e. Discharge summary. When the facility anticipates discharges, a resident shall have a discharge summary that includes:

   (1) A recapitulation of the resident’s stay.
   (2) A final summary of the resident’s status to include items in paragraph “b,” subparagraph (2) above, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.
   (3) A postdischarge plan of care developed with the participation of the resident and resident’s family which will assist the resident to adjust to a new living environment.

  f. Reserved.

  g. Preadmission resident assessment. The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

81.13(10) Quality of care. Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

  a. Activities of daily living. Based on the comprehensive assessment of a resident, the facility shall ensure that:

   (1) A resident’s abilities in activities of daily living do not diminish unless circumstances of the individual’s clinical condition demonstrate that diminution was unavoidable. This includes the resident’s ability to bathe, dress and groom; transfer and ambulate; toilet; eat, and to use speech, language or other functional communication systems.
   (2) A resident is given the appropriate treatment and services to maintain or improve the resident’s abilities specified in subparagraph (1) above.
   (3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

  b. Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility shall, if necessary, assist the resident:

   (1) In making appointments.
   (2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision impairment or the deaf or hard of hearing or the office of a professional specializing in the provision of vision or hearing assistive devices.

  c. Pressure sores. Based on the comprehensive assessment of a resident, the facility shall ensure that:

   (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual’s clinical condition demonstrates that they were unavoidable.
   (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
d. Urinary incontinence. Based on the resident’s comprehensive assessment, the facility shall ensure that:

1. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization was necessary.

2. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

e. Range of motion. Based on the comprehensive assessment of a resident, the facility shall ensure that:

1. A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident’s clinical condition demonstrates that a reduction in range of motion is unavoidable.

2. A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.

f. Mental and psychosocial functioning. Based on the comprehensive assessment of a resident, the facility shall ensure that:

1. A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

2. A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident’s clinical condition demonstrates that such a pattern was unavoidable.

g. Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility shall ensure that:

1. A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident’s clinical condition demonstrates that use of a naso-gastric tube was unavoidable.

2. A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers and to restore, if possible, normal eating skills.

h. Accidents. The facility shall ensure that:

1. The resident environment remains as free of accident hazards as is possible.

2. Each resident receives adequate supervision and assistive devices to prevent accidents.

i. Nutrition. Based on a resident’s comprehensive assessment, the facility shall ensure that a resident:

1. Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident’s clinical condition demonstrates that this is not possible.

2. Receives a therapeutic diet when there is a nutritional problem.

j. Hydration. The facility shall provide each resident with sufficient fluid intake to maintain proper hydration and health.

k. Special needs. The facility shall ensure that residents receive proper treatment and care for the following special services:

1. Injections.

2. Parenteral and enteral fluids.

3. Colostomy, ureterostomy or ileostomy care.

4. Tracheostomy care.

5. Tracheal suctioning.

6. Respiratory care.

7. Foot care.

8. Prostheses.

l. Unnecessary drugs.

1. General. Each resident’s drug regimen shall be free from unnecessary drugs. An unnecessary drug is any drug when used:

1. In excessive dose including duplicate drug therapy; or

2. For excessive duration; or
3. Without adequate monitoring; or
4. Without adequate indications for its use; or
5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
6. Any combinations of the reasons above.

(2) Antipsychotic drugs. Based on a comprehensive assessment of a resident, the facility shall ensure that:
   a. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.
   b. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

m. Medication errors. The facility shall ensure that:
   (1) It is free of significant medication error rates of 5 percent or greater.
   (2) Residents are free of any significant medication errors.

81.13(11) Nursing services. The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

a. Sufficient staff.
   (1) The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
      1. Except when waived under paragraph “c,” licensed nurses.
      2. Other nursing personnel.
   (2) Except when waived under paragraph “c,” the facility shall designate a licensed nurse to serve as a charge nurse on each tour of duty.

b. Registered nurse.
   (1) Except when waived under paragraph “c,” the facility shall use the services of a registered nurse for at least eight consecutive hours a day, seven days a week.
   (2) Except when waived under paragraph “c,” the facility shall designate a registered nurse to serve as the director of nursing on a full-time basis.
   (3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

c. Nursing facilities. Waiver of requirement to provide licensed nurses on a 24-hour basis. A facility may request a waiver from either the requirement that a nursing facility provide a registered nurse for at least eight consecutive hours a day, seven days a week, as specified in paragraph “b,” or the requirement that a nursing facility provide licensed nurses on a 24-hour basis, including a charge nurse as specified in paragraph “a,” if the following conditions are met:
   (1) The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.
   (2) The department of inspections and appeals determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.
   (3) The department of inspections and appeals finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.
   (4) A waiver granted under the conditions listed in paragraph “c” is subject to annual department of inspections and appeals review.
   (5) In granting or renewing a waiver, a facility may be required by the department of inspections and appeals to use other qualified, licensed personnel.
   (6) The department of inspections and appeals shall provide notice of a waiver granted under this paragraph to the state long-term care ombudsman established under Section 307(a)(12) of the Older

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Americans Act of 1965 and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(7) The nursing facility that is granted a waiver under this paragraph shall notify residents of the facility or, where appropriate, the guardians or legal representatives of the residents and members of their immediate families of the waiver.

81.13(12) Dietary services. The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

a. Staffing. The facility shall employ a qualified dietitian either full-time, part-time or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is licensed by the state according to Iowa Code chapter 152A.

b. Sufficient staff. The facility shall employ sufficient support personnel competent to carry out the functions of the dietary service.

c. Menus and nutritional adequacy. Menus shall:

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(2) Be prepared in advance.

(3) Be followed.

d. Food. Each resident receives and the facility provides:

(1) Food prepared by methods that conserve nutritive value, flavor and appearances.

(2) Food that is palatable, attractive and at the proper temperature.

(3) Food prepared in a form designed to meet individual needs.

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

e. Therapeutic diets. Therapeutic diets shall be prescribed by the attending physician.

f. Frequency of meals.

(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There shall be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in subparagraph (4) below.

(3) The facility shall offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

g. Assistive devices. The facility shall provide special eating equipment and utensils for residents who need them.

h. Sanitary conditions. The facility shall:

(1) Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(2) Store, prepare, distribute and serve food under sanitary conditions.

(3) Dispose of garbage and refuse properly.

81.13(13) Physician services. A physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

a. Physician supervision. The facility shall ensure that:

(1) The medical care of each resident is supervised by a physician.

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

b. Physician visits. The physician shall:

(1) Review the resident’s total program of care, including medications and treatments, at each visit required by paragraph “c” below.

(2) Write, sign and date progress notes at each visit.

(3) Sign and date all orders.

c. Frequency of physician visits.
(1) The resident shall be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(2) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(3) Except as provided in paragraph “e,” all required physician visits shall be made by the physician personally.

   d. Availability of physicians for emergency care. The facility shall provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

   e. Performance of physician tasks in nursing facilities. Any required physician task in a nursing facility (including tasks which the rules specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility, but who is working in collaboration with a physician except where prohibited by state law.

81.13(14) Specialized services. When indicated, specialized services shall be provided to residents as follows:

   a. Specialized rehabilitative services. Specialized rehabilitative services shall be provided by qualified personnel under the written order of a physician. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, and occupational therapy, are required in the resident’s comprehensive plan of care, the facility shall:

      (1) Provide the required services; or

      (2) Obtain the required services from an outside provider of specialized rehabilitative services.

   b. Specialized services for mental illness. “Specialized services for mental illness” means services provided in response to an exacerbation of a resident’s mental illness that:

      (1) Are beyond the normal scope and intensity of nursing facility responsibility;

      (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

      (3) Are provided through a professionally developed plan of care with specific goals and interventions;

      (4) May be provided only by a specialized licensed or certified practitioner;

      (5) Are expected to result in specific, identified improvements in the resident’s psychiatric status to the level before the exacerbation of the resident’s mental illness; and

      (6) May include:

         1. Acute inpatient psychiatric treatment. When inpatient psychiatric treatment may be prevented through specialized services provided in the nursing facility, services provided in the nursing facility are preferred.

         2. Initial psychiatric evaluation to determine a resident’s diagnosis and to develop a plan of care.

         3. Follow-up psychiatric services by a psychiatrist to evaluate resident response to psychotropic medications, to modify medication orders and to evaluate the need for ancillary therapy services.

         4. Psychological testing required for a specific differential diagnosis that will result in the adoption of appropriate treatment services.

         5. Individual or group psychotherapy as part of a plan of care addressing specific symptoms.

         6. Any clinically appropriate service which is available for which the member meets eligibility criteria.

   c. Specialized services for intellectual disability. “Specialized services for intellectual disability” means services that:

      (1) Are beyond the normal scope and intensity of nursing facility responsibility;

      (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

      (3) Are provided through a professionally developed plan of care with specific goals and interventions;

      (4) Must be supervised by a qualified intellectual disability professional; and

      (5) May include:
2. Development and implementation of a behavioral support plan.
3. Community living skills training for members who desire to live in a community setting and for whom community living is appropriate as determined by the Level II evaluation. Training may include adaptive behavior skills, communication skills, social skills, personal care skills, and self-advocacy skills.

81.13(15) Dental services. The facility shall assist residents in obtaining routine and 24-hour emergency dental care. The facility shall:
   a. Provide or obtain from an outside resource the following dental services to meet the needs of each resident:
      (1) Routine dental services to the extent covered under the state plan.
      (2) Emergency dental services.
   b. If necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist’s office.
   c. Promptly refer residents with lost or damaged dentures to a dentist.

81.13(16) Pharmacy services. The facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed pharmacist.
   a. Procedures. A facility shall provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.
   b. Service consultation. The facility shall employ or obtain the services of a licensed pharmacist who:
      (1) Provides consultation on all aspects of the provision of pharmacy services in the facility.
      (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.
      (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
   c. Drug regimen review.
      (1) The drug regimen of each resident shall be reviewed at least once a month by a licensed pharmacist.
      (2) The pharmacist shall report any irregularities to the attending physician and the director of nursing, and these reports shall be acted upon.
   d. Labeling of drugs and biologicals. Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.
   e. Storage of drugs and biologicals.
      (1) In accordance with state and federal laws, the facility shall store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.
      (2) The facility shall provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
   f. Consultant pharmacists. When the facility does not employ a licensed pharmacist, it shall have formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals. The formal arrangements with the licensed pharmacist shall include separate written contracts for pharmaceutical vendor services and consultant pharmacist services. The consultant’s visits are scheduled to be of sufficient duration and at a time convenient to work with nursing staff on the resident care plan, consult with the administrator and others on developing and implementing policies and procedures, and planning in-service training and staff development for employees. The consultant shall provide monthly
drug regimen review reports. The facility shall provide reimbursement for consultant pharmacists based on fair market value. Documentation of consultation shall be available for review in the facility.

81.13(17) Infection control. The facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

a. Infection control program. The facility shall establish an infection control program under which it:

(1) Investigates, controls and prevents infections in the facility.
(2) Decides what procedures, such as isolation, should be applied to an individual resident.
(3) Maintains a record of incidents and corrective actions related to infections.

b. Preventing spread of infection.

(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility shall isolate the resident.
(2) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility shall require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

c. Linens. Personnel shall handle, store, process, and transport linens so as to prevent the spread of infection.

81.13(18) Physical environment. The facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

a. Life safety from fire. Except as provided in subparagraph (1) or (3) below, the facility shall meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association.

(1) A facility is considered to be in compliance with this requirement as long as the facility:
   1. On November 26, 1982, complied with or without waivers with the requirements of the 1967 or 1973 editions of the Life Safety Code and continues to remain in compliance with those editions of the code; or

(2) When Medicaid nursing facilities and Medicaid distinct part nursing facility providers request a waiver of Life Safety Code requirements in accordance with Subsection 1919(d)(2)(B)(i) of the Social Security Act, the department of inspections and appeals shall forward the requests to the Centers for Medicare and Medicaid Services Regional Office for review and approval.

(3) The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare and Medicaid Services finds that a fire and safety code imposed by state law adequately protects patients, residents and personnel in long-term care facilities.

b. Emergency power.

(1) An emergency electrical power system shall supply power adequate at least for lighting all entrances and exits, equipment to maintain the fire detection, alarm and extinguishing systems, and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used that have no nonelectrical backup, the facility shall provide emergency electrical power with an emergency generator, as defined in NFPA 99, Health Care Facilities, that is located on the premises.

c. Space and equipment. The facility shall:

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident’s plan of care.

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

d. Resident rooms. Resident rooms shall be designed and equipped for adequate nursing care, comfort and privacy of residents.
(1) Bedrooms shall:
   1. Accommodate no more than four residents.
   2. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.
   3. Have direct access to an exit corridor.
   4. Be designed or equipped to ensure full visual privacy for each resident.
   5. In facilities initially certified after March 31, 1992, except in private rooms, each bed shall have ceiling-suspended curtains, which extend around the bed to provide total visual privacy, in combination with adjacent walls and curtains.
   6. Have at least one window to the outside.
   7. Have a floor at or above grade level.
   (2) The facility shall provide each resident with:
   1. A separate bed of proper size and height for the convenience of the resident.
   2. A clean, comfortable mattress.
   3. Bedding appropriate to the weather and climate.
   4. Functional furniture appropriate to the resident’s needs and individual closet space in the resident’s bedroom with clothes racks and shelves accessible to the resident.
   (3) The department of inspections and appeals may permit variations in requirements specified in paragraph “d,” subparagraph (1), numbers 1 and 2 above relating to rooms in individual cases when the facility demonstrates in writing that the variations are required by the special needs of the residents and will not adversely affect residents’ health and safety.
   e. Toilet facilities. Each resident room shall be equipped with or located adjacent to toilet facilities unless a waiver is granted by the department of inspections and appeals. Additionally, each resident room shall be equipped with or located adjacent to bathing facilities.
   f. Resident call system. The nurse’s station shall be equipped to receive resident calls through a communication system from:
      (1) Resident rooms.
      (2) Toilet and bathing facilities.
   g. Dining and resident activities. The facility shall provide one or more rooms designated for resident dining and activities. These rooms shall:
      (1) Be well lighted.
      (2) Be well ventilated, with nonsmoking areas identified.
      (3) Be adequately furnished.
      (4) Have sufficient space to accommodate all activities.
   h. Other environmental conditions. The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The facility shall:
      (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.
      (2) Have adequate outside ventilation by means of windows or mechanical ventilation or a combination of the two.
      (3) Equip corridors with firmly secured handrails on each side.
      (4) Maintain an effective pest control program so that the facility is free of pests and rodents.

81.13(19) Administration. A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.
   a. Licensure. A facility shall be licensed under applicable state and federal law.
   b. Compliance with federal, state and local laws and professional standards. The facility shall operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.
   c. Relationship to other Department of Health and Human Services (HHS) regulations. In addition to compliance with these rules, facilities shall meet the applicable provisions of other HHS
regulations, including, but not limited to, those pertaining to nondiscrimination on the basis of race, color, or national origin, nondiscrimination on the basis of handicap, nondiscrimination on the basis of age, protection of human subjects of research, and fraud and abuse. Although these regulations are not in themselves considered requirements under these rules, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with federal funds.

d. Governing body.
(1) The facility shall have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.
(2) The governing body appoints the administrator who is:
   1. Licensed by the state.
   2. Responsible for management of the facility.

e. Required training of nurse aides.
(1) Definitions.
   “Licensed health professional” means a physician; physician assistant; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.
   “Nurse aide” means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.
(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis, unless:
   1. That person is competent to provide nursing and nursing-related services.
   2. That person has completed a training and competency evaluation program or a competency evaluation program approved by the department of inspections and appeals; or that person has been deemed or determined competent by the department of inspections and appeals.
(3) Nonpermanent employees. A facility shall not use on a temporary, per diem, leased, or any basis other than a permanent employee any person who does not meet the requirements in subparagraph (2).
(4) Competency. A facility shall not use any person who has worked less than four months as a nurse aide in that facility unless the person:
   1. Is a permanent employee and is in a nurse aide training and competency evaluation program approved by the department of inspections and appeals;
   2. Has demonstrated competence through satisfactory participation in a nurse aide training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals; or
   3. Has been deemed or determined competent by the department of inspections and appeals.
(5) Registry verification. Before allowing a person to serve as a nurse aide, a facility shall receive registry verification that the person has met competency evaluation requirements unless:
   1. The person is a permanent employee and is in a training and competency evaluation program approved by the department of inspections and appeals; or
   2. The person can prove that the person has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals and has not yet been included in the registry. Facilities shall follow up to ensure that such a person actually becomes registered.
(6) Multistate registry verification. Before allowing a person to serve as a nurse aide, a facility shall seek information from every state registry the facility believes will include information on the person.
(7) Required retraining. If since October 1, 1990, there has been a continuous period of 24 consecutive months during none of which the person provided nursing or nursing-related services for monetary compensation, the person shall complete a new training and competency evaluation program or a new competency evaluation program.
(8) Regular in-service education. The facility shall complete a performance review of every nurse aide at least once every 12 months and shall provide regular in-service education based on the outcome of these reviews. The in-service training shall:

1. Be sufficient to ensure the continuing competencies of nurse aides, but shall be no less than 12 hours per year.
2. Address areas of weakness as determined in nurse aides’ performance reviews and may address the special needs of residents as determined by the facility staff.
3. For nurse aides providing services to persons with cognitive impairments, also address the care of the cognitively impaired.

f. Proficiency of nurse aides. The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.

g. Staff qualifications.

(1) The facility shall employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation.

(2) Professional staff shall be licensed, certified or registered in accordance with applicable state laws.

h. Use of outside resources.

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in subparagraph (2) below.

(2) Arrangements or agreements pertaining to services furnished by outside resources shall specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and for the timeliness of the services.

i. Medical director.

(1) The facility shall designate a physician to serve as medical director.

(2) The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

j. Laboratory services.

(1) The facility shall provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of the services furnished by laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.
2. If the facility provides blood bank and transfusion services, it shall meet the requirements for laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.
3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved or licensed to test specimens in the appropriate specialties or subspecialties of service in accordance with 42 CFR Part 493 as amended to October 1, 1990.
4. If the facility does not provide laboratory services on site, it shall have an agreement to obtain these services only from a laboratory that meets the requirements of 42 CFR Part 493 as amended to October 1, 1990, or from a physician’s office.

(2) The facility shall:

1. Provide or obtain laboratory services only when ordered by the attending physician.
2. Promptly notify the attending physician of the findings.
3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.
4. File in the resident’s clinical record signed and dated reports of clinical laboratory services.

k. Radiology and other diagnostic services.
(1) The facility shall provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own diagnostic services, the services shall meet the applicable conditions of participation for hospitals.
2. If the facility does not provide its own diagnostic services, it shall have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

(2) The facility shall:
1. Provide or obtain radiology and other diagnostic services only when ordered by the attending physician.
2. Promptly notify the attending physician of the findings.
3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.
4. File in the resident’s clinical record signed and dated reports of X-ray and other diagnostic services.

l. Clinical records.

(1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.

(2) Clinical records shall be retained for:
1. The period of time required by state law.
2. Five years from the date of discharge when there is no requirement in state law.
3. For a minor, three years after a resident reaches legal age under state law.

(3) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use.

(4) The facility shall keep confidential all information contained in the resident’s records, regardless of the form or storage method of the records, except when release is required by:
1. Transfer to another health care institution.
2. Law.
3. Third-party payment contract.
4. The resident.

(5) The clinical record shall contain:
1. Sufficient information to identify the resident.
2. A record of the resident’s assessments.
3. The plan of care and services provided.
4. The results of any preadmission screening conducted by the state.
5. Progress notes.

m. Disaster and emergency preparedness.

(1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.

n. Transfer agreement.

(1) The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably ensures that:
1. Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician.
2. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether the residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.
(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

   o. Quality assessment and assurance.
      (1) A facility shall maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility’s staff.
      (2) The quality assessment and assurance committee:
         1. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.
         2. Develops and implements appropriate plans of action to correct identified quality deficiencies.
      (3) The state or the Secretary of the Department of Health and Human Services may not require disclosure of the records of the committee except insofar as the disclosure is related to the compliance of the committee with the requirements of this paragraph.
      (4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

      (1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104.
      (2) The facility shall provide written notice to the department of inspections and appeals at the time of change, if a change occurs in:
         1. Persons with an ownership or control interest.
         2. The officers, directors, agents, or managing employees.
         3. The corporation, association, or other company responsible for the management of the facility.
         4. The facility’s administrator or director of nursing.
      (3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a,” and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4900C, IAB 2/12/20, effective 3/18/20; ARC 5305C, IAB 12/2/20, effective 2/1/21; ARC 5808C, IAB 7/28/21, effective 9/1/21]

441—81.14(249A) Audits.

81.14(1) Audit of financial and statistical report. Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—81.6(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

   a. When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the health facility shall be suspended and eventually canceled from the nursing facility program, or

   b. When a health facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

81.14(2) Audit of proper billing and handling of patient funds.

   a. The Iowa Medicaid enterprise, the department’s contracted managed care organizations, field auditors of the department of inspections and appeals, and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the
department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The Iowa Medicaid enterprise, the department’s contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.4(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph “d,” the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general’s office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a” and 249A.4.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.15 Reserved.

441—81.16(249A) Nurse aide requirements and training and testing programs.

81.16(1) Deemed meeting of requirements. A nurse aide is deemed to satisfy the requirement of completing a nurse aide training and competency evaluation approved by the department of inspections and appeals if:

a. The nurse aide successfully completed a nurse aide training and competency evaluation program before July 1, 1989, and

(1) At least 60 clock hours were substituted for 75 clock hours, and the person has made up at least the difference in the number of clock hours in the program the person completed and 75 clock hours in supervised practical nurse aide training or in regular in-service nurse aide education, or

(2) The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 clock hours’ duration, or

(3) The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989, or

(4) The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections and appeals determines would have met the requirements for approval at the time it was offered; or

b. The person is a veteran, an active duty service member, or a member of the reserve forces, who has:

(1) Successfully completed a U.S. military training program that includes a curriculum comparable to the nurse aide training program required by this rule and has documented successful completion of that program with either a diploma, certifications, or Form DD 214 showing completion of hospital corpsman or medical service specialist or equivalent training, and

(2) Provided documentation showing that the person has 75 clock hours of practical experience in a nurse aide role, which may include classroom instruction, prior equivalent experience, or a combination of the two, and
(3) Successfully completed the nurse aide training and competency examination.

**81.16(2)** State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.

a. The department of inspections and appeals shall, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of 81.13(19) “e” and 81.16(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections and appeals approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of 81.16(3).

2. A nurse aide competency evaluation program meets the requirements of 81.16(4).

(2) Except as provided by paragraph 81.16(2) “f,” the department of inspections and appeals shall not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or

2. Has been subject to an extended or partial extended survey; or

3. Has been assessed a civil money penalty of not less than $5,000; or

4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility’s residents; or

5. Pursuant to state action, was closed or had its residents transferred; or

6. Has been terminated from participation in the Medicaid or Medicare program; or

7. Has been denied payment under subrule 81.40(1) or 81.40(2).

c. Application process. Applications shall be submitted to the department of inspections and appeals before a new program begins and every two years thereafter on Form 427-0517, Application for Nurse Aide Training. The department of inspections and appeals shall, within 90 days of the date of a request or receipt of additional information from the requester:

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections and appeals shall not grant approval of a nurse aide training and competency evaluation program for a period longer than two years. A program shall notify the department of inspections and appeals and the department of inspections and appeals shall review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval.

(1) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in 81.16(2) “b” (2).

(2) The department of inspections and appeals may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the department of inspections and appeals determines that any of the applicable requirements for approval or registry, as set out in subrule 81.16(3) or 81.16(4), are not met.

(3) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the department of inspections and appeals.

(4) If the department of inspections and appeals withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started a training and competency evaluation program from which approval has been withdrawn shall be allowed to complete the course.
f. An exception to subparagraph 81.16(2) “b”(2) may be granted by the department of inspections and appeals (DIA) for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:
   (1) The facility has submitted Form 470-3494, Nurse Aide Education Program Waiver Request, to the DIA to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.
   (2) The 75-hour nurse aide training is offered in a facility by an approved nurse aide training and competency evaluation program (NATCEP).
   (3) No other NATCEP program is offered within 30 minutes’ travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.
   (4) The facility is in substantial compliance with the federal requirements related to nursing care and services.
   (5) The facility is not a poor performing facility.
   (6) Employees of the facility do not function as instructors for the program unless specifically approved by DIA.
   (7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.
   (8) The NATCEP has submitted an evaluation to the DIA indicating that an adequate teaching and learning environment exists for conducting the course.
   (9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.
   (10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP which shall return the evaluations to DIA.

81.16(3) Requirements for approval of a nurse aide training and competency evaluation program. The department has designated the department of inspections and appeals to approve required nurse aide training and competency evaluation programs. Policies and procedures governing approval of the programs are set forth in these rules.
   a. For a nurse aide training and competency evaluation program to be approved, such program shall, at a minimum:
      (1) Consist of no less than 75 clock hours of training, and
      (2) Include at least the subjects specified in 81.16(3) “b,” and
      (3) Include at least 30 hours of didactic theory instruction, which may be provided in a classroom setting or through online course curricula, and
      (4) Include at least 16 hours of laboratory experience provided in a face-to-face environment that complements the didactic theory curricula, and
      (5) Include 30 hours of supervised clinical training in a face-to-face environment and supervised by a department of inspections and appeals-approved instructor in a manner not inconsistent with the licensing requirements of the Iowa board of nursing. In extenuating circumstances, a laboratory setting may be utilized in place of face-to-face clinical training subject to the department’s approval, and
      (6) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the department of inspections and appeals-approved instructor, and
      (7) Meet the following requirements for department of inspections and appeals-approved instructors who train nurse aides:
         1. The training of nurse aides shall be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which shall be in the provision of long-term care facility services.
         2. Instructors shall be registered nurses and shall have completed a course in teaching adults or have experience teaching adults or supervising nurse aides.
3. In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed by registered nurses under the general supervision of the director of nursing for the facility. The director of nursing is prohibited from performing the actual training.

4. Other personnel from the health professions as set forth in 42 CFR 483.152(5) may supplement the instructor. Supplemental personnel shall have at least one year of experience in their fields.

5. The ratio of department of inspections and appeals-approved instructors to students shall not exceed one registered nurse, or licensed practical nurse functioning as an assistant to a registered nurse, who is in the proximate area in the clinical setting, for every 15 students in the clinical setting, and

8. Contain information regarding competency evaluation through written or oral examination and skills demonstration.

b. The curriculum of the nurse aide training program shall include:

1. At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:
   1. Communication and interpersonal skills.
   2. Infection control.
   3. Safety and emergency procedures including the Heimlich maneuver.
   4. Promoting residents’ independence.
   5. Respecting residents’ rights.

2. Basic nursing skills:
   1. Taking and recording vital signs.
   3. Caring for the residents’ environment.
   4. Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor.

3. Caring for residents when death is imminent.

4. Personal care skills, including, but not limited to:
   1. Bathing.
   2. Grooming, including mouth care.
   3. Dressing.
   4. Toileting.
   5. Assisting with eating and hydration.
   6. Proper feeding techniques.
   7. Skin care.

5. Transfers, positioning, and turning.

4. Mental health and social service needs:
   1. Modifying aide’s behavior in response to residents’ behavior.
   2. Awareness of developmental tasks associated with the aging process.
   3. How to respond to resident behavior.
   4. Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident’s dignity.

5. Using the resident’s family as a source of emotional support.

5. Care of cognitively impaired residents:

1. Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer’s and others).

2. Communicating with cognitively impaired residents.

3. Understanding the behavior of cognitively impaired residents.

4. Appropriate responses to the behavior of cognitively impaired residents.

5. Methods of reducing the effects of cognitive impairments.

6. Basic restorative services:
   1. Training the resident in self-care according to the resident’s ability.
   2. Use of assistive devices in transferring, ambulation, eating and dressing.
   3. Maintenance of range of motion.
4. Proper turning and positioning in bed and chair.
5. Bowel and bladder training.
6. Care and use of prosthetic and orthotic devices.
(7) Residents’ rights:
1. Providing privacy and maintenance of confidentiality.
2. Promoting the residents’ rights to make personal choices to accommodate their needs.
3. Giving assistance in resolving grievances and disputes.
4. Providing needed assistance in getting to and participating in resident and family groups and other activities.
5. Maintaining care and security of residents’ personal possessions.
6. Promoting the residents’ rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff.
7. Avoiding the need for restraints in accordance with current professional standards.
   c. Prohibition of charges.
   (1) A nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program may not be charged for any portion of the program including any fees for textbooks, course materials, or nurse aide competency evaluations.
   (2) If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility no later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:
      1. Add all costs incurred by the nurse aide for the course, books, and competency evaluations.
      2. Divide the total arrived at in paragraph “1” above by 12 to prorate the costs over a one-year period and establish a monthly rate.
      3. The nurse aide shall be reimbursed the monthly rate each month the nurse aide works at the facility until one year from the time the nurse aide completed the course.
         d. Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.
         e. Records and reports. Nurse aide education programs approved by the department of inspections and appeals shall:
            (1) Notify the department of inspections and appeals:
               1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.
               2. When a facility or other training entity will no longer be offering nurse aide training courses.
               3. Whenever the person coordinating the training program is hired or terminates employment.
            (2) Keep a list of faculty members and their qualifications available for department review.
            (3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.
            (4) Complete a lesson plan for each unit which includes behavioral objectives, a topic outline and student activities and experiences.
            (5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.

81.16(4) Nurse aide competency evaluation. A competency evaluation program shall contain a written or oral portion and a skills demonstration portion.
   a. Notification to person. The department of inspections and appeals shall advise in advance any person who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the state’s nurse aide registry.
   b. Content of the competency evaluation program.
      (1) Written or oral examinations. The competency evaluation shall:
1. Allow an aide to choose between a written and oral examination.
2. Address each of the course requirements listed in 81.16(3) “b.”
3. Be developed from a pool of test questions, only a portion of which is used in any one examination.
4. Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.
5. If oral, be read from a prepared text in a neutral manner.
6. Be tested for reliability and validity using a nationally recognized standard as determined by the department of education.
7. Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English.

(2) Demonstration of skills. The skills demonstration evaluation shall consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills shall include all of the personal care skills listed in 81.16(3) “b” (3).
   a. Administration of the competency evaluation.
      (1) The competency examination shall be administered and evaluated only by an entity approved by the department of inspections and appeals, which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.
      (2) Charging nurse aides for competency testing is prohibited in accordance with 81.16(3) “c.”
      (3) The skills demonstration part of the evaluation shall be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide and shall be administered and evaluated by a registered nurse with at least one year’s experience in providing care for the elderly or the chronically ill of any age.
      d. Facility proctoring of the competency evaluation.
         (1) The competency evaluation may, at the nurse aide’s option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is prohibited from being a competency evaluation site.
         (2) The department of inspections and appeals may permit the competency evaluation to be proctored by facility personnel if the department of inspections and appeals finds that the procedure adopted by the facility ensures that the competency evaluation program:
            1. Is secure from tampering.
            2. Is standardized and scored by a testing, educational, or other organization approved by the department of inspections and appeals.
            3. Requires no scoring by facility personnel.
         (3) The department of inspections and appeals shall retract the right to proctor nurse aide competency evaluations from facilities in which the department of inspections and appeals finds any evidence of impropriety, including evidence of tampering by facility staff.
      e. Successful completion of the competency evaluation program.
         (1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.
         (2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.
      (3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide’s scores within 20 calendar days after the test is administered.
   f. Unsuccessful completion of the competency evaluation program.
      (1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:
         1. Of the areas which the person did not pass.
         2. That the person has three opportunities to take the evaluation.
(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

g. Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

h. Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections and appeals. The department of inspections and appeals shall notify the applicant of its decision within 90 days of receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

81.16(5) Registry of nurse aides.

a. Establishment of registry. The department of inspections and appeals shall establish and maintain a registry of nurse aides that meets the following requirements. The registry:

  (1) Shall include, at a minimum, the information required in 81.16(5) “c.”
  (2) Shall be sufficiently accessible to meet the needs of the public and health care providers promptly.
  (3) Shall provide that any response to an inquiry that includes a finding of abuse, neglect, mistreatment of a resident or misappropriation of property also include any statement made by the nurse aide which disputes the finding.

b. Registry operation.

  (1) Only the department of inspections and appeals may place on the registry findings of abuse, neglect, mistreatment of a resident or misappropriation of property.
  (2) The department of inspections and appeals shall determine which persons:
      1. Have successfully completed a nurse aide training and competency evaluation program or nurse aide competency evaluation program.
      2. Have been deemed as meeting these requirements.
      3. Do not qualify to remain on the registry because they have performed no nursing or nursing-related services for monetary compensation during a period of 24 consecutive months.
      (3) The department of inspections and appeals shall not impose any charges related to registration on persons listed in the registry.
  (4) The department of inspections and appeals shall provide information on the registry promptly.

c. Registry content.

  (1) The registry shall contain at least the following information on each person who has successfully completed a nurse aide training and competency evaluation program or competency evaluation program which was approved by the department of inspections and appeals or who may function as a nurse aide because of having been deemed competent:
      1. The person’s full name.
      2. Information necessary to identify each person.
      3. The date the person became eligible for placement in the registry through successfully completing a nurse aide training and competency evaluation program or competency evaluation or by being deemed competent.
  4. The following information on any finding by the department of inspections and appeals of abuse, neglect, mistreatment of residents or misappropriation of property by the person: documentation of the department of inspections and appeals’ investigation, including the nature of the allegation and the evidence that led the department of inspections and appeals to conclude that the allegation was valid; the date of the hearing, if the person chose to have one, and its outcome; and a statement by the person disputing the allegation, if the person chooses to make one. This information must be included in the registry within ten working days of the finding and shall remain in the registry permanently, unless the finding was made in error, the person was found not guilty in a court of law, or the department of inspections and appeals is notified of the person’s death.
5. A record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment or misappropriation of resident property.

(2) The registry shall remove entries for persons who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months unless the person’s registry entry includes documented findings or convictions by a court of law of abuse, neglect, mistreatment or misappropriation of property.

d. Disclosure of information. The department of inspections and appeals shall:

(1) Disclose all of the information listed in 81.16(5)“c”(1), (3), and (4) to all requesters and may disclose additional information it deems necessary.

(2) Promptly provide persons with all information contained in the registry about them when adverse findings are placed on the registry and upon request. Persons on the registry shall have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

e. Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry. The telephone number of the registry is (515)281-4963. The address is Nurse Aide Registry, Lucas State Office Building, Des Moines, Iowa 50319-0083.

(1) Persons employed as nurse aides shall complete Form 427-0496, Nurse Aide Registry Application, within the first 30 days of employment. This form shall be submitted to the department of inspections and appeals. Form 427-0496 may be obtained by calling or writing the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed Form 427-0496 to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, a letter will be sent to the nurse aide that includes all the information the registry has on the nurse aide. A nurse aide may obtain a copy of the information on the registry by writing the nurse aide registry and requesting the information. The letter requesting the information must include the nurse aide’s social security number, current or last facility of employment, date of birth and current mailing address and must be signed by the nurse aide.

81.16(6) Hearing. When there is an allegation of abuse against a nurse aide, the department of inspections and appeals shall investigate that allegation. When the investigation by the department of inspections and appeals makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections and appeals. The hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

81.16(7) Appeals. Adverse decisions made by the department of inspections and appeals in administering these rules may be appealed pursuant to department of inspections and appeals rules 481—Chapter 10.

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

[ARC 3718C, IAB 3/28/18, effective 5/2/18; ARC 6391C, IAB 6/29/22, effective 9/1/22]

441—81.17 Reserved.

441—81.18(249A) Sanctions.

81.18(1) Penalty for falsification of a resident assessment. An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty of not less than $100 or more than $1,000 for each falsified assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not less than $500 nor more than $5,000 for each falsified assessment. These fines shall be administratively assessed by the department of inspections and appeals.
a. Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections and appeals or the director’s designee may consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:
   (1) The number of assessments willingly and knowingly falsified.
   (2) The history of the individual relative to previous assessment falsifications.
   (3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.
   (4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.
   (5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

b. Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

c. Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections and appeals in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and department of inspections and appeals rules 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections and appeals may petition for judicial review in the manner provided by Iowa Code chapter 17A.

81.18(2) Use of independent assessors. If the department of inspections and appeals determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections and appeals may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.
   a. Criteria used to determine the need for independent assessors shall include:
      (1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.
      (2) The facility’s response to the falsification of or causing resident assessments to be falsified.
      (3) The method used to prepare facility staff to do resident assessments.
      (4) The number of individuals involved in the falsification.
      (5) The number of falsified resident assessments.
      (6) The extent of harm to residents caused by the falsifications.
   b. The department of inspections and appeals will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.
   c. The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections and appeals before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.
   d. Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.
   e. Criteria for removal of the requirement for independent assessors.
      (1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.
      (2) The facility shall submit a plan to the department of inspections and appeals for completing its own assessments.
      (3) The department of inspections and appeals will evaluate the facility’s proposal for ensuring assessments will not be falsified in the future.
   f. Appeal procedures.
(1) A written notice to appeal shall be postmarked or personally served to the department of inspections and appeals within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision which may be appealed to the director of the department of inspections and appeals pursuant to department of inspections and appeals rules 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

81.18(3) Penalty for notification of time or date of survey. Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed $2,000.

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

441—81.19 Reserved.

441—81.20(249A) Out-of-state facilities. Payment will be made for care in out-of-state nursing facilities. For members enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

81.20(1) Out-of-state providers. Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state-operated nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)’f”(1) plus the non-direct care rate limit pursuant to subparagraph 81.6(16)’f”(1), whichever is lower.

a. Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)’f”(3) plus the non-direct care rate component limit pursuant to subparagraph 81.6(16)’f”(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

b. Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.6(16)’e”(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

81.20(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).
81.20(3) Effective December 1, 2009, payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at zero percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—81.21(249A) Outpatient services. Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, House File 479, section 132, subsection 1, paragraph "i."

441—81.22(249A) Rates for Medicaid eligibles.

81.22(1) Maximum client participation. A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to 441 — subrule 79.1(9) or rule 441—81.6(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

81.22(2) Beginning date of payment. When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident’s Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident’s client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning and renewal date of eligibility and resident client participation amounts may be obtained through the Iowa Medicaid portal access (IMPA) system. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 1806C, IAB 1/7/15, effective 3/1/15]

441—81.23(249A) State-funded personal needs supplement. A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than $50 per month shall receive a state-funded payment from the department for the difference between that countable income and $50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code section 249A.30A.
[ARC 6226C, IAB 3/9/22, effective 5/1/22]

441—81.24 to 81.30 Reserved.

DIVISION II
ENFORCEMENT OF COMPLIANCE

PREAMBLE

These rules specify remedies that may by used when a nursing facility is not in substantial compliance with the requirements for participation in the Medicaid program. These rules also provide for ensuring prompt compliance and specify that these remedies are in addition to any others available under state or federal law.

441—81.31(249A) Definitions.

“CMS” means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

“Deficiency” means a nursing facility’s failure to meet a participation requirement.
“Department” means the Iowa department of human services.

“Immediate jeopardy” means a situation in which immediate corrective action is necessary because the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

“New admission” means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor are they subject to the denial of payment.

“Noncompliance” means any deficiency that causes a facility to not be in substantial compliance.

“Plan of correction” means a plan developed by the facility and approved by the department of inspections and appeals which describes the actions the facility shall take to correct deficiencies and specifies the date by which those deficiencies shall be corrected.

“Standard survey” means a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation.

“Substandard quality of care” means one or more deficiencies related to the participation requirements for resident behavior and facility practices, quality of life, or quality of care which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

“Substantial compliance” means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

“Temporary management” means the temporary appointment by the department of inspections and appeals of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility’s operation.

441—81.32(249A) General provisions.

81.32(1) Purpose of remedies. The purpose of remedies is to ensure prompt compliance with program requirements.

81.32(2) Basis for imposition and duration of remedies. The department of inspections and appeals, as the state survey agency under contract with the department, determines the remedy to be applied for noncompliance with program requirements. When the department of inspections and appeals chooses to apply one or more remedies specified in rule 441—81.34(249A), the remedies are applied on the basis of noncompliance found during surveys conducted by the department of inspections and appeals.

81.32(3) Number of remedies. The department of inspections and appeals may apply one or more remedies for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

81.32(4) Plan of correction requirement.

a. Except as specified in paragraph “b,” regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements shall submit a plan of correction for approval by the department of inspections and appeals.

b. A facility is not required to submit a plan of correction when the department of inspections and appeals determines the facility has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

81.32(5) Disagreement regarding remedies. If the department of inspections and appeals and CMS disagree on the decision to impose a remedy, the disagreement shall be resolved in accordance with rule 441—81.55(249A).

81.32(6) Notification requirements.

a. The department of inspections and appeals shall give the provider written notice of remedy, including the:
(1) Nature of the noncompliance.
(2) Which remedy is imposed.
(3) Effective date of the remedy.
(4) Right to appeal the determination leading to the remedy.
   b. Except for civil money penalties and state monitoring imposed when there is immediate
   jeopardy, for all remedies specified in rule 441—81.34(249A) imposed when there is immediate
   jeopardy, the notice shall be given at least two calendar days before the effective date of the enforcement
   action.
   c. Except for civil money penalties and state monitoring, notice shall be given at least 15 calendar
   days before the effective date of the enforcement action in situations where there is no immediate
   jeopardy.
   d. The 2- and 15-day notice periods begin when the facility receives the notice, but in no event
   will the effective date of the enforcement action be later than 20 calendar days after the notice is sent.
   e. For civil money penalties, the notices shall be given in accordance with rules 441—81.48(249A)
   and 441—81.51(249A).
   f. For state monitoring imposed when there is immediate jeopardy, no prior notice is required.
   81.32(7) Informal dispute resolution.
   a. Opportunity to refute survey findings.
      (1) For nonfederal surveys, the department of inspections and appeals (DIA) shall offer a facility
      an informal opportunity, at the facility’s request, to dispute survey findings upon the facility’s receipt of
      the official statement of deficiencies.
      (2) For a federal survey, the Centers for Medicare and Medicaid Services (CMS) offers a facility
      an informal opportunity, at the facility’s request, to dispute survey findings upon the facility’s receipt of
      the official statement of deficiencies.
   b. Delay of enforcement action.
      (1) Failure of DIA or CMS, as appropriate, to complete informal dispute resolution timely cannot
      delay the effective date of any enforcement action against the facility.
      (2) A facility may not seek a delay of any enforcement action against it on the grounds that informal
      dispute resolution has not been completed before the effective date of the enforcement action.
   c. If a provider is subsequently successful, during the informal dispute resolution process,
      at demonstrating that deficiencies should not have been cited, the deficiencies are removed from
      the statement of deficiencies and any enforcement actions imposed solely as a result of those cited
      deficiencies are rescinded.
   d. Notification. DIA shall provide the facility with written notification of the informal dispute
      resolution process.

441—81.33(249A) Factors to be considered in selecting remedies.

81.33(1) Initial assessment. In order to select the appropriate remedy, if any, to apply to a facility
with deficiencies, the department of inspections and appeals shall determine the seriousness of the
deficiencies.

81.33(2) Determining seriousness of deficiencies. To determine the seriousness of the deficiency,
the department of inspections and appeals shall consider at least the following factors:
   a. Whether a facility’s deficiencies constitute:
      (1) No actual harm with a potential for minimal harm.
      (2) No actual harm with a potential for more than minimal harm, but not immediate jeopardy.
      (3) Actual harm that is not immediate jeopardy.
      (4) Immediate jeopardy to resident health or safety.
   b. Whether the deficiencies:
      (1) Are isolated.
      (2) Constitute a pattern.
      (3) Are widespread.
81.33(3) *Other factors which may be considered in choosing a remedy within a remedy category.* Following the initial assessment, the department of inspections and appeals may consider other factors, which may include, but are not limited to, the following:

a. The relationship of the one deficiency to other deficiencies resulting in noncompliance.
b. The facility’s prior history of noncompliance in general and specifically with reference to the cited deficiencies.

441—81.34(249A) **Available remedies.** In addition to the remedy of termination of the provider agreement, the following remedies are available:

1. Temporary management.
2. Denial of payment for all new admissions.
3. Civil money penalties.
4. State monitoring.
5. Closure of the facility in emergency situations or transfer of residents, or both.
6. Directed plan of correction.
7. Directed in-service training.

441—81.35(249A) **Selection of remedies.**

81.35(1) **Categories of remedies.** Remedies specified in rule 441—81.34(249A) are grouped into categories and applied to deficiencies according to the severity of noncompliance.

81.35(2) **Application of remedies.** After considering the factors specified in rule 441—81.33(249A), if the department of inspections and appeals applies remedies, as provided in paragraphs 81.35(3)“c,” 81.35(4)“a,” and 81.35(5)“a,” for facility noncompliance, instead of, or in addition to, termination of the provider agreement, the department of inspections and appeals shall follow the criteria set forth in 81.35(3)“b,” 81.35(4)“b,” and 81.35(5)“b,” as applicable.

81.35(3) **Category 1.**

a. Category 1 remedies include the following:
   (1) Directed plan of correction.
   (2) State monitoring.
   (3) Directed in-services training.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 1 when there:
   (1) Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
   (2) Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 1 to any deficiency.

81.35(4) **Category 2.**

a. Category 2 remedies include the following:
   (1) Denial of payment for new admissions.
   (2) Civil money penalties of $50 to $3,000 per day.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 2 when there are:
   (1) Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
   (2) One or more deficiencies that constitute actual harm that is not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 2 to any deficiency.

81.35(5) **Category 3.**

a. Category 3 remedies include the following:
   (1) Temporary management.
(2) Immediate termination.

(3) Civil money penalties of $3,050 to $10,000 per day.

b. When there is one or more deficiencies that constitute immediate jeopardy to resident health or safety, one or both of the following remedies shall be applied:

(1) Temporary management.

(2) Termination of the provider agreement.

In addition the department of inspections and appeals may impose a civil money penalty of $3,050 to $10,000 per day.

c. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, the department of inspections and appeals may impose temporary management, in addition to Category 2 remedies.

81.35(6) Plan of correction.  

a. Except as specified in paragraph “b,” each facility that has a deficiency with regard to a requirement for long-term care facilities shall submit a plan of correction for approval by the department of inspections and appeals, regardless of:

(1) Which remedies are applied.

(2) The seriousness of the deficiencies.

b. When there are only isolated deficiencies that the department of inspections and appeals determines constitute no actual harm with a potential for minimal harm, the facility need not submit a plan of correction.

81.35(7) Appeal of a determination of noncompliance.  

a. A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections and appeals within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

(1) A request for a hearing shall be made in writing to the department of inspections and appeals within 60 days from receipt of the notice.

b. Hearings shall be conducted pursuant to department of inspections and appeals rules 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections and appeals as the final decision maker, with subject matter jurisdiction.

(2) A facility may not appeal the choice of remedy, including the factors considered by the department of inspections and appeals in selecting the remedy.

b. A facility may not challenge the level of noncompliance found by the department of inspections and appeals, except that in the case of a civil money penalty, a facility may challenge the level of noncompliance found by the department of inspections and appeals only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

d. Except when a civil money penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

441—81.36(249A) Action when there is immediate jeopardy.  

81.36(1) Terminate agreement or appoint temporary manager: If there is immediate jeopardy to resident health or safety, the department of inspections and appeals shall appoint a temporary manager to remove the immediate jeopardy or the provider agreement shall be terminated within 23 calendar days of the last date of the survey.

The rules for appointment of a temporary manager in an immediate jeopardy situation are as follows:

a. The department of inspections and appeals shall notify the facility that a temporary manager is being appointed.

b. If the facility fails to relinquish control to the temporary manager, the provider agreement shall be terminated within 23 calendar days of the last day of the survey if the immediate jeopardy is not removed. In these cases, state monitoring may be imposed pending termination.
c. If the facility relinquishes control to the temporary manager, the department of inspections and appeals shall notify the facility that, unless it removes the immediate jeopardy, its provider agreement shall be terminated within 23 calendar days of the last day of the survey.

d. The provider agreement shall be terminated within 23 calendar days of the last day of survey if the immediate jeopardy has not been removed.

81.36(2) Other remedies. The department of inspections and appeals may also impose other remedies, as appropriate.

81.36(3) Notification of CMS. In a nursing facility or dually participating facility, if the department of inspections and appeals finds that a facility’s noncompliance poses immediate jeopardy to resident health or safety, the department of inspections and appeals shall notify CMS of the finding.

81.36(4) Transfer of residents. The department shall provide for the safe and orderly transfer of residents when the facility is terminated from participation.

81.36(5) Notification of physicians and state board. If the immediate jeopardy is also substandard quality of care, the department of inspections and appeals shall notify attending physicians and the Iowa board of nursing home administrators of the finding of substandard quality of care.

441—81.37(249A) Action when there is no immediate jeopardy.

81.37(1) Termination of agreement or limitation of participation. If a facility’s deficiencies do not pose immediate jeopardy to residents’ health or safety, and the facility is not in substantial compliance, the facility’s provider agreement may be terminated or the facility may be allowed to continue to participate for no longer than six months from the last day of the survey if:

a. The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility’s provider agreement;

b. The department of inspections and appeals has submitted a plan of correction approved by CMS; and

c. The facility agrees to repay payments received after the last day of the survey that first identified the deficiencies if corrective action is not taken in accordance with the approved plan of correction and posts bond acceptable to the department to guarantee the repayment.

81.37(2) Termination. If a facility does not meet the criteria for continuation of payment under subrule 81.37(1), the facility’s provider agreement shall be terminated.

81.37(3) Denial of payment. Payment shall be denied for new admissions when the facility is not in substantial compliance three months after the last day of the survey.

81.37(4) Failure to comply. The provider agreement shall be terminated and all payments stopped to a facility for which participation was continued under subrule 81.37(1) if the facility is not in substantial compliance within six months of the last day of the survey.

441—81.38(249A) Action when there is repeated substandard quality of care.

81.38(1) General. If a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies provided:

a. Payment for all new admissions shall be denied, as specified in rule 441—81.40(249A).

b. The department of inspections and appeals shall impose state monitoring, as specified in rule 441—81.42(249A) until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with all requirements and will remain in substantial compliance with all requirements.

81.38(2) Repeated noncompliance. For purposes of this rule, repeated noncompliance is based on the repeated finding of substandard quality of care and not on the basis that the substance of the deficiency or the exact deficiency was repeated.

81.38(3) Standard surveys to which this provision applies. Standard surveys completed by the department of inspections and appeals on or after October 1, 1990, are used to determine whether the threshold of three consecutive standard surveys is met.

81.38(4) Program participation.
a. The determination that a certified facility has repeated instances of substandard quality of care is made without regard to any variances in the facility’s program participation (that is, any standard survey completed for Medicare, Medicaid or both programs will be considered).
b. Termination would allow the count of repeated substandard quality of care surveys to start over.
c. Change of ownership.
   (1) A facility may not avoid a remedy on the basis that it underwent a change of ownership.
   (2) In a facility that has undergone a change of ownership, the department of inspections and appeals may not restart the count of repeated substandard quality of care surveys unless the new owner can demonstrate to the department of inspections and appeals that the poor past performance no longer is a factor due to the change in ownership.

81.38(5) Compliance. Facility alleges corrections or achieves compliance after repeated substandard quality of care is identified.
   a. If a penalty is imposed for repeated substandard quality of care, it will continue until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with the requirements and that it will remain in substantial compliance for a period of time specified by the department of inspections and appeals.
   b. A facility will not avoid the imposition of remedies or the obligation to demonstrate that it will remain in compliance when it:
      (1) Alleges correction of the deficiencies cited in the most recent standard survey; or
      (2) Achieves compliance before the effective date of the remedies.

441—81.39(249A) Temporary management. The department of inspections and appeals may appoint a temporary manager from qualified applicants.

81.39(1) Qualifications. The temporary manager must:
   a. Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the department of inspections and appeals.
   b. Not have been found guilty of misconduct by any licensing board or professional society in any state.
   c. Have, or a member of the manager’s immediate family have, no financial ownership interest in the facility.
   d. Not currently serve or, within the past two years, have served as a member of the staff of the facility.

81.39(2) Payment of salary. The temporary manager’s salary:
   a. Is paid directly by the facility while the temporary manager is assigned to that facility.
   b. Shall be at least equivalent to the sum of the following:
      (1) The prevailing salary paid by providers for positions of this type in the facility’s geographic area.
      (2) Additional costs that would have reasonably been incurred by the provider if the person had been in an employment relationship.
      (3) Any other transportation and lodging costs incurred by the person in furnishing services under the arrangement up to the maximum per diem for state employees.
   c. May exceed the amount specified in paragraph “b” if the department of inspections and appeals is otherwise unable to attract a qualified temporary manager.

81.39(3) Failure to relinquish authority to temporary management.
   a. If a facility fails to relinquish authority to the temporary manager, the provider agreement shall be terminated in accordance with rule 441—81.57(249A).
   b. A facility’s failure to pay the salary of the temporary manager is considered a failure to relinquish authority to temporary management.

81.39(4) Duration of temporary management. Temporary management ends when the facility meets any of the conditions specified in subrule 81.56(3).

441—81.40(249A) Denial of payment for all new admissions.
81.40(1) *Optional denial of payment.* Except as specified in subrule 81.40(2), the denial of payment for all new admissions may be imposed when a facility is not in substantial compliance with the requirements.

81.40(2) *Required denial of payment.* Payment for all new admissions shall be denied when:
   a. The facility is not in substantial compliance three months after the last day of the survey identifying the noncompliance; or
   b. The department of inspections and appeals has cited a facility with substandard quality of care on the last three consecutive standard surveys.

81.40(3) *Resumption of payments.* Repeated instances of substandard quality of care. When a facility has repeated instances of substandard quality of care, payments to the facility resume on the date that:
   a. The facility achieves substantial compliance as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.
   b. The department of inspections and appeals determines that the facility is capable of remaining in substantial compliance.

81.40(4) *Resumption of payments.* No repeated instances of substandard quality of care. When a facility does not have repeated instances of substandard quality of care, payments to the facility resume prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

81.40(5) *Restriction.* No payments to a facility are made for the period between the date that the denial of payment remedy is imposed and the date the facility achieves substantial compliance, as determined by the department of inspections and appeals.

441—81.41(249A) *Secretarial authority to deny all payments.*

81.41(1) *CMS option to deny all payment.* If a facility has not met a requirement, in addition to the authority to deny payment for all new admissions as specified in rule 441—81.40(249A), CMS may deny any further payment to the state for all Medicaid residents in the facility. When CMS denies payment to the state, the department shall deny payment to the facility.

81.41(2) *Resumption of payment.* When CMS resumes payment to the state, the department shall also resume payment to the facility. The department shall make payments to the facility for the same periods for which payment is made to the state.

441—81.42(249A) *State monitoring.*

81.42(1) *State monitor,* A state monitor:
   a. Oversees the correction of deficiencies specified by the department of inspections and appeals at the facility site and protects the facility’s residents from harm.
   b. Is an employee or a contractor of the department of inspections and appeals.
   c. Is identified by the department of inspections and appeals as an appropriate professional to monitor cited deficiencies.
   d. Is not an employee of the facility.
   e. Does not function as a consultant to the facility.
   f. Does not have an immediate family member who is a resident of the facility to be monitored.

81.42(2) *Use of state monitor,* A state monitor shall be used when the department of inspections and appeals has cited a facility with substandard quality of care deficiencies on the last three consecutive standard surveys.

81.42(3) *Discontinuance of state monitor,* State monitoring is discontinued when:
   a. The facility has demonstrated that it is in substantial compliance with the requirement, and it will remain in compliance for a period of time specified by the department of inspections and appeals.
   b. Termination procedures are completed.
441—81.43(249A) Directed plan of correction. The department of inspections and appeals or the temporary manager (with department of inspections and appeals’ approval) may develop a plan of correction and require a facility to take action within specified time frames.

441—81.44(249A) Directed in-service training.

81.44(1) Required training. The department of inspections and appeals may require the staff of a facility to attend an in-service training program if:
   a. The facility has a pattern of deficiencies that indicate noncompliance; and
   b. Education is likely to correct the deficiencies.

81.44(2) Action following training. After the staff has received in-service training, if the facility has not achieved substantial compliance, the department of inspections and appeals may impose one or more other remedies.

81.44(3) Payment. The facility is responsible for the payment for the directed in-service training.

441—81.45(249A) Closure of a facility or transfer of residents, or both.

81.45(1) Closure during an emergency. In an emergency, the department and the department of inspections and appeals have the authority to:
   a. Transfer Medicaid and Medicare residents to another facility; or
   b. Close the facility and transfer the Medicaid and Medicare residents to another facility.

81.45(2) Required transfer in immediate jeopardy situations. When a facility’s provider agreement is terminated for a deficiency that constitutes immediate jeopardy, the department arranges for the safe and orderly transfer of all Medicaid and Medicare residents to another facility.

81.45(3) All other situations. Except for immediate jeopardy situations, as specified in subrule 81.45(2), when a facility’s provider agreement is terminated, the department arranges for the safe and orderly transfer of all Medicaid and Medicare residents to another facility.

441—81.46(249A) Civil money penalties—basis for imposing penalty. The department of inspections and appeals may impose a civil money penalty for the number of days a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy.

The department of inspections and appeals may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

441—81.47(249A) Civil money penalties—when penalty is collected.

81.47(1) When facility requests a hearing.
   a. A facility shall request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty within the time limit specified in subrule 81.35(7).
   b. If a facility requests a hearing within the time specified in subrule 81.35(7), the department of inspections and appeals initiates collection of the penalty when there is a final administrative decision that upholds the department of inspections and appeals’ determination of noncompliance after the facility achieves substantial compliance or is terminated.

81.47(2) When facility does not request a hearing. If a facility does not request a hearing, in accordance with subrule 81.47(1), the department of inspections and appeals initiates collection of the penalty when the facility:
   a. Achieves substantial compliance; or
   b. Is terminated.

81.47(3) When facility waives a hearing. If a facility waives its right to a hearing in writing, as specified in rule 441—81.49(249A), the department of inspections and appeals initiates collection of the penalty when the facility:
   a. Achieves substantial compliance; or
   b. Is terminated.
81.47(4) Accrual and computation of penalties. Accrual and computation of penalties for a facility that:

a. Requests a hearing or does not request a hearing as specified in rule 441—81.50(249A);
b. Waives its right to a hearing in writing, as specified in subrule 81.49(2) and rule 441—81.50(249A).

81.47(5) Collection. The collection of civil money penalties is made as provided in rule 441—81.52(249A).

441—81.48(249A) Civil money penalties—notice of penalty. The department of inspections and appeals shall notify the facility of intent to impose a civil money penalty in writing. The notice shall include, at a minimum, the following information:

1. The nature of the noncompliance.
2. The statutory basis for the penalty.
3. The amount of penalty per day of noncompliance.
4. Any factors specified in subrule 81.50(6) that were considered when determining the amount of the penalty.
5. The date on which the penalty begins to accrue.
6. When the penalty stops accruing.
7. When the penalty is collected.
8. Instructions for responding to the notice, including a statement of the facility’s right to a hearing, and the implication of waiving a hearing, as provided in rule 441—81.49(249A).

441—81.49(249A) Civil money penalties—waiver of hearing, reduction of penalty amount.

81.49(1) Waiver of a hearing. The facility may waive the right to a hearing, in writing, within 60 days from the date of the notice of intent to impose the civil money penalty.

81.49(2) Reduction of penalty amount.

a. If the facility waives its right to a hearing, the department of inspections and appeals reduces the civil money penalty amount by 35 percent.
b. If the facility does not waive its right to a hearing, the civil money penalty is not reduced by 35 percent.

441—81.50(249A) Civil money penalties—amount of penalty.

81.50(1) Amount of penalty. The penalties are within the following ranges, set at $50 increments:

a. Upper range—$3,050 to $10,000. Penalties in the range of $3,050 to $10,000 per day are imposed for deficiencies constituting immediate jeopardy, as specified in 81.50(4) “b.”
b. Lower range—$50 to $3,000. Penalties in the range of $50 to $3,000 per day are imposed for deficiencies that do not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm, but have the potential for more than minimal harm.

81.50(2) Basis for penalty amount. The amount of penalty is based on the department of inspections and appeals’ assessment of factors listed in subrule 81.50(6).

81.50(3) Decreased penalty amounts. Except as specified in 81.50(4) “b,” if immediate jeopardy is removed, but the noncompliance continues, the department of inspections and appeals shall shift the penalty amount to the lower range.

81.50(4) Increased penalty amounts.

a. Before the hearing, the department of inspections and appeals may propose to increase the penalty amount for facility noncompliance which, after imposition of a lower level penalty amount, becomes sufficiently serious to pose immediate jeopardy.
b. The department of inspections and appeals shall increase the penalty amount for any repeated deficiencies for which a lower level penalty amount was previously imposed, regardless of whether the increased penalty amount would exceed the range otherwise reserved for nonimmediate jeopardy deficiencies.
c. Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.

81.50(5) Review of the penalty. When an administrative law judge (or director of the department of inspections and appeals) finds that the basis for imposing a civil money penalty exists, the administrative law judge (or director) may not:
   a. Set a penalty of zero or reduce a penalty to zero.
   b. Review the exercise of discretion by the department of inspections and appeals to impose a civil money penalty.
   c. Consider any factors in reviewing the amount of the penalty other than those specified in subrule 81.50(6).

81.50(6) Factors affecting the amount of penalty. In determining the amount of penalty, the department of inspections and appeals shall take into account the following factors:
   a. The facility’s history of noncompliance, including repeated deficiencies.
   b. The facility’s financial condition.
   c. The factors specified in rule 441—81.33(249A).
   d. The facility’s degree of culpability. Culpability includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.

81.50(7) Authority to settle penalties. The department of inspections and appeals has the authority to settle cases at any time before the evidentiary hearing.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]

441—81.51(249A) Civil money penalties—effective date and duration of penalty.

81.51(1) When penalty begins to accrue. The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by the department of inspections and appeals.

81.51(2) Duration of penalty. The civil money penalty is computed and collectible, as specified in rules 441—81.47(249A) and 441—81.52(249A), for the number of days of noncompliance until the date the facility achieves substantial compliance or, if applicable, the date of termination when:
   a. The department of inspections and appeals’ decision of noncompliance is upheld after a final administrative decision;
   b. The facility waives its right to a hearing in accordance with rule 441—81.49(249A); or
   c. The time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(3) Penalty due. The entire accrued penalty is due and collectible, as specified in the notice sent to the provider under subrules 81.51(4) and 81.54(5).

81.51(4) Notice after facility achieves compliance. When a facility achieves substantial compliance, the department of inspections and appeals shall send a separate notice to the facility containing:
   a. The amount of penalty per day;
   b. The number of days involved;
   c. The total amount due;
   d. The due date of the penalty; and
   e. The rate of interest assessed on the unpaid balance beginning on the due date, as provided in rule 441—81.52(249A).

81.51(5) Notice to terminated facility. In the case of a terminated facility, the department of inspections and appeals shall send this penalty information after the:
   a. Final administrative decision is made;
   b. Facility has waived its right to a hearing in accordance with rule 441—81.49(249A); or
   c. Time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

81.51(6) Accrual of penalties when there is no immediate jeopardy.
   a. In the case of noncompliance that does not pose immediate jeopardy, the daily accrual of civil money penalties is imposed for the days of noncompliance prior to the notice specified in rule
441—81.48(249A) and an additional period of no longer than six months following the last day of the survey.

b. After the period specified in paragraph “a,” if the facility has not achieved substantial compliance, the provider agreement may be terminated.

81.51(7) Accrual of penalties when there is immediate jeopardy.

a. When a facility has deficiencies that pose immediate jeopardy, the provider agreement shall be terminated within 23 calendar days after the last day of the survey if the immediate jeopardy remains.

b. The accrual of the civil money penalty stops on the day the provider agreement is terminated.

81.51(8) Documenting substantial compliance.

a. If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to the department of inspections and appeals that substantial compliance was achieved on a date preceding the revisit, penalties only accrue until that date of correction for which there is written credible evidence.

b. If an on-site revisit is not necessary to confirm substantial compliance, penalties only accrue until the date of correction for which the department of inspections and appeals receives and accepts written credible evidence.

441—81.52(249A) Civil money penalties—due date for payment of penalty.

81.52(1) When payments are due.

a. A civil money penalty payment is due 15 days after a final administrative decision is made when:

1. The facility achieves substantial compliance before the final administrative decision; or
2. The effective date of termination occurs before the final administrative decision.

b. A civil money penalty is due 15 days after the time period for requesting a hearing has expired and a hearing request was not received when:

1. The facility achieves substantial compliance before the hearing request was due; or
2. The effective date of termination occurs before the hearing request was due.

c. A civil money penalty payment is due 15 days after receipt of the written request to waive a hearing when:

1. The facility achieved substantial compliance before the department of inspections and appeals received the written waiver of hearing; or
2. The effective date of termination occurs before the department of inspections and appeals received the written waiver of hearing.

d. A civil money penalty payment is due 15 days after substantial compliance is achieved when:

1. The final administrative decision is made before the facility came into compliance;
2. The facility did not file a timely hearing request before it came into substantial compliance; or
3. The facility waived its right to a hearing before it came into substantial compliance.

e. A civil money penalty payment is due 15 days after the effective date of termination, if before the effective date of termination:

1. The final administrative decision was made;
2. The time for requesting a hearing has expired and the facility did not request a hearing; or
3. The facility waived its right to a hearing.

f. In the cases specified in paragraph “d,” the period of noncompliance may not extend beyond six months from the last day of the survey.

81.52(2) Deduction of penalty from amount owed. The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

81.52(3) Interest. Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

[ARC 9402B, IAB 3/9/11, effective 4/1/11]
441—81.53(249A) Use of penalties collected by the department. Civil money penalties collected by the department shall be applied to the protection of the health or property of residents of facilities that the department of inspections and appeals finds deficient. Funds may be used for:

1. Time-limited expenses incurred in the process of relocating residents to home- and community-based settings or other facilities when a facility is closed or downsized pursuant to an agreement with the department;
2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;
3. Support and protection of residents of a facility that closes;
4. Funding of projects to improve the quality of life and quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166;
5. Projects that support resident and family councils and other consumer involvement in ensuring quality care in facilities; and
6. Reasonable expenses incurred by the department to administer, monitor, or evaluate the effectiveness of grants utilizing civil money penalty funds.

[ARC 9402B, IAB 3/9/11, effective 4/1/11; ARC 3717C, IAB 3/28/18, effective 7/1/18]

441—81.54(249A) Continuation of payments to a facility with deficiencies.

81.54(1) Criteria.

a. The department may continue payments to a facility that is not in substantial compliance for the periods specified in subrule 81.54(3) if the following criteria are met:
   (1) The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility;
   (2) The department of inspections and appeals has submitted a plan and timetable for corrective action approved by CMS; and
   (3) The facility agrees to repay the department for all payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action and posts a bond acceptable to the department to guarantee agreement to repay.

b. The facility provider agreement may be terminated before the end of the correction period if the criteria in 81.54(1)“a” are not met.

81.54(2) Cessation of payments. If termination is not sought, either by itself or along with another remedy or remedies, or any of the criteria in 81.54(1)“a” are not met or agreed to by either the facility or the department, the facility shall receive no payments, as applicable, from the last day of the survey.

81.54(3) Period of continued payments. If the conditions in 81.54(1)“a” are met, the department may continue payments to a facility with noncompliance that does not constitute immediate jeopardy for up to six months from the last day of the survey.

81.54(4) Failure to achieve substantial compliance. If the facility does not achieve substantial compliance by the end of the period specified in subrule 81.54(3), the provider agreement for the facility may be terminated.

441—81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy. This rule applies when CMS and the department of inspections and appeals disagree over findings of noncompliance or application of remedies.

81.55(1) Disagreement over whether facility has met requirements.

a. The department of inspections and appeals’ finding of noncompliance takes precedence when:
   (1) CMS finds the facility is in substantial compliance with the participation requirements; and
   (2) The department of inspections and appeals finds the facility has not achieved substantial compliance.

b. CMS’s findings of noncompliance take precedence when:
   (1) CMS finds that a facility has not achieved substantial compliance; and
   (2) The department of inspections and appeals finds the facility is in substantial compliance with the participation requirements.
c. When CMS’s survey findings take precedence, CMS may:
   (1) Impose any of the alternative remedies specified in rule 441—81.34(249A);
   (2) Terminate the provider agreement subject to the applicable conditions of rule 441—81.54(249A); and
   (3) Stop federal financial participation to the department for a nursing facility.

81.55(2) Disagreement over decision to terminate.
   a. CMS’s decision to terminate the participation of a facility takes precedence when:
      (1) Both CMS and the department of inspections and appeals find that the facility has not achieved substantial compliance; and
      (2) CMS, but not the department of inspections and appeals, finds that the facility’s participation should be terminated. CMS will permit continuation of payment during the period prior to the effective date of termination, not to exceed six months, if the applicable conditions of rule 441—81.54(249A) are met.
   b. The department of inspections and appeals’ decision to terminate a facility’s participation and the procedures for appealing the termination take precedence when:
      (1) The department of inspections and appeals, but not CMS, finds that a facility’s participation should be terminated; and
      (2) The department of inspections and appeals’ effective date for the termination of the nursing facility’s provider agreement is no later than six months after the last day of survey.

81.55(3) Disagreement over timing of termination of facility. The department of inspections and appeals’ timing of termination takes precedence if it does not occur later than six months after the last day of the survey when both CMS and the department of inspections and appeals find that:
   a. A facility is not in substantial compliance; and
   b. The facility’s participation should be terminated.

81.55(4) Disagreement over remedies.
   a. When CMS or the department of inspections and appeals, but not both, establishes one or more remedies, in addition to or as an alternative to termination, the additional or alternative remedies will also apply when:
      (1) Both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance; and
      (2) Both CMS and the department of inspections and appeals find that no immediate jeopardy exists.
   b. When CMS and the department of inspections and appeals establish one or more remedies, in addition to or as an alternative to termination, only the CMS remedies apply when both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance.

81.55(5) One decision. Regardless of whether CMS’s or the department of inspections and appeals’ decision controls, only one noncompliance and enforcement decision is applied to the Medicaid agreement, and for a dually participating facility, that same decision will apply to the Medicare agreement.

441—81.56(249A) Duration of remedies.

81.56(1) Remedies continue. Except as specified in subrule 81.56(2), alternative remedies continue until:
   a. The facility has achieved substantial compliance as determined by the department of inspections and appeals based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or
   b. The provider agreement is terminated.

81.56(2) State monitoring. In the cases of state monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until:
   a. The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or
   b. The provider agreement is terminated.
81.56(3) **Temporary management.** In the case of temporary management, the remedy continues until:

- The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance;
- The provider agreement is terminated; or
- The facility which has not achieved substantial compliance reassumes management control. In this case, the department of inspections and appeals initiates termination of the provider agreement and may impose additional remedies.

81.56(4) **Facility in compliance.** If the facility can supply documentation acceptable to the department of inspections and appeals that it was in substantial compliance, and was capable of remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that the department of inspections and appeals can verify as the date that substantial compliance was achieved.

441—81.57(249A) **Termination of provider agreement.**

81.57(1) **Effect of termination.** Termination of the provider agreement ends payment to the facility and any alternative remedy.

81.57(2) **Basis of termination.**

- A facility’s provider agreement may be terminated if a facility:
  1. Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or
  2. Fails to submit an acceptable plan of correction within the time frame specified by the department of inspections and appeals.

- A facility’s provider agreement shall be terminated if a facility:
  1. Fails to relinquish control to the temporary manager, if that remedy is imposed by the department of inspections and appeals; or
  2. Does not meet the eligibility criteria for continuation of payment as set forth in 81.37(1) “a.”

81.57(3) **Notice of termination.** Before a provider agreement is terminated, the department of inspections and appeals shall notify the facility and the public:

- At least two calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and
- At least 15 calendar days before the effective date of termination for a facility with nonimmediate jeopardy deficiencies that constitute noncompliance.

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

[Filed June 21, 1973; amended June 3, 1975]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed 2/25/77, Notice 1/12/77—published 3/23/77, effective 5/1/77]
[Filed 10/24/77, Notice 9/7/77—published 11/16/77, effective 12/21/77]
[Filed 11/7/78, Notice 4/19/78—published 11/29/78, effective 1/3/79]
[Filed 10/24/79, Notice 5/30/79—published 11/14/79, effective 12/19/79]
[Filed 10/24/79, Notice 9/5/79—published 11/14/79, effective 12/19/79]
[Filed 2/14/80, Notice 8/22/79—published 3/5/80, effective 4/9/80]
[Filed 7/3/80, Notice 4/16/80—published 7/23/80, effective 8/27/80]
[Filed 12/19/80, Notice 10/29/80—published 1/7/81, effective 2/11/81]
[Filed 2/12/81, Notice 1/7/81—published 3/4/81, effective 4/8/81]
[Filed 6/30/81, Notice 4/29/81—published 7/22/81, effective 9/1/81]
[Filed 7/23/81, Notice 5/27/81—published 8/19/81, effective 9/23/81]
[Filed 11/20/81, Notice 10/14/81—published 12/9/81, effective 2/1/82]
[Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
[Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]
[Filed 7/1/82, Notice 4/28/82—published 7/21/82, effective 9/1/82]
[Filed 8/20/82, Notice 6/23/82—published 9/15/82, effective 10/20/82]
[Filed 9/23/82, Notice 8/4/82—published 10/13/82, effective 12/1/82]
[Filed emergency 1/14/83—published 2/2/83, effective 1/14/83]
[Filed 3/25/83, Notice 1/19/83—published 4/13/83, effective 6/1/83]
[Filed 5/20/83, Notice 4/13/83—published 6/8/83, effective 8/1/83]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed 9/19/83, Notice 4/27/83—published 10/12/83, effective 12/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 3/1/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed 11/1/84, Notice 9/12/84—published 11/21/84, effective 1/1/85]
[Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
[Filed 6/14/85, Notice 5/8/85—published 7/3/85, effective 9/1/85]
[Filed 8/23/85, Notice 7/3/85—published 9/11/85, effective 11/1/85]
[Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
[Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
[Filed 10/18/85, Notice 8/28/85—published 11/6/85, effective 1/1/86]
[Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
[Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
[Filed 9/26/86, Notice 8/13/86—published 10/22/86, effective 12/1/86]
[Filed 12/22/86, Notice 10/22/86—published 1/14/87, effective 3/1/87]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 10/27/88, Notice 8/24/88—published 11/16/88, effective 1/1/89]
[Filed emergency 11/16/88 after Notice 10/5/88—published 12/14/88, effective 1/1/89]
[Filed emergency 6/8/89 after Notice 2/22/89—published 6/28/89, effective 7/1/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed emergency 2/14/90—published 3/7/90, effective 2/14/90]
[Filed 3/16/90, Notice 11/15/90—published 4/4/90, effective 6/1/90]
[Filed emergency 6/19/90—published 7/11/90, effective 7/1/90]
[Filed 7/13/90, Notices 3/7/90, 5/30/90—published 8/8/90, effective 10/1/90]
[Filed 8/16/90, Notice 6/27/90—published 9/5/90, effective 11/1/90]
[Filed 9/28/90, Notices 7/11/90, 8/8/90—published 10/17/90, effective 12/1/90]
[Filed emergency 11/14/90—published 12/12/90, effective 12/1/90]
[Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
[Filed 6/14/91, Notices 3/20/91, 5/1/91—published 7/10/91, effective 9/1/91]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
[Filed 10/10/91, Notice 8/21/91—published 10/30/91, effective 1/1/92]
[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 4/8/92]
[Filed without Notice 5/14/92—published 6/10/92, effective 7/15/92]3
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
[Filed 1/14/93, Notice 12/9/92—published 2/3/93, effective 4/1/93]
[Filed 3/11/93, Notice 1/20/93—published 3/31/93, effective 6/1/93]4
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
[Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 9/15/94, Notice 7/6/94—published 10/12/94, effective 12/1/94]
[Filed emergency 4/12/95—published 5/10/95, effective 4/12/95]
[Filed 4/13/95, Notice 3/1/95—published 5/10/95, effective 7/1/95]
[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
[Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
[Filed 11/16/95, Notice 9/27/95—published 12/6/95, effective 2/1/96]
[Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
[Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
[Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
[Filed emergency 5/13/98—published 6/3/98, effective 6/22/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed 7/15/98, Notice 6/3/98—published 8/12/98, effective 10/1/98]
[Filed emergency 8/12/98—published 9/9/98, effective 8/12/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 9/15/98, Notice 7/29/98—published 10/7/98, effective 12/1/98]
[Filed 10/14/98, Notice 9/9/98—published 11/4/98, effective 1/1/99]
[Filed 11/10/98, Notice 8/26/98—published 12/2/98, effective 2/1/99]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 11/10/99, Notice 9/22/99—published 12/1/99, effective 2/1/00]
[Filed 4/12/00, Notice 3/8/00—published 5/3/00, effective 7/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
[Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
[Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02]
[Filed 1/9/02, Notice 10/31/01—published 2/6/02, effective 3/13/02]
[Filed 1/9/02, Notice 11/28/01—published 2/6/02, effective 4/1/02]
[Filed emergency 1/16/02—published 2/6/02, effective 2/1/02]5
[Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
[Filed 2/13/03, Notice 12/25/02—published 3/5/03, effective 5/1/03]
[Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
[Filed emergency 11/19/03—published 12/10/03, effective 12/1/03]
[Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
[Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
[Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
[Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
[Filed emergency 5/12/06—published 6/7/06, effective 6/1/06]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
[Filed 7/14/06, Notice 6/7/06—published 8/2/06, effective 9/6/06]
[Filed 11/8/06, Notice 7/5/06—published 12/6/06, effective 1/10/07]
[Filed 2/15/07, Notice 12/20/06—published 3/14/07, effective 5/1/07]
[Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
[Filed emergency 11/14/07 after Notice 9/26/07—published 12/5/07, effective 11/15/07]
[Filed 4/10/08, Notice 1/30/08—published 5/7/08, effective 7/1/08]
[Filed without Notice 7/9/08—published 7/30/08, effective 9/3/08]
[Filed 10/14/08, Notice 7/30/08—published 11/5/08, effective 12/10/08]
[Filed ARC 8258B (Notice ARC 8086B, IAB 8/26/09), IAB 11/4/09, effective 1/1/10]
[Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
[Filed Emergency After Notice ARC 8445B (Notice ARC 8246B, IAB 10/21/09), IAB 1/13/10, effective 12/11/09]
[Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]
[Filed ARC 8994B (Notice ARC 8756B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10]
[Filed Without Notice ARC 8995B, IAB 8/11/10, effective 9/15/10]
[Filed Emergency ARC 9046B, IAB 9/8/10, effective 8/12/10]
[Filed Emergency After Notice ARC 9402B (Notice ARC 9157B, IAB 10/20/10), IAB 3/9/11, effective 4/1/11]
[Filed Emergency ARC 9726B, IAB 9/7/11, effective 9/1/11]
[Filed ARC 9888B (Notice ARC 9727B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed ARC 0714C (Notice ARC 0590C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]
[Filed ARC 1151C (Notice ARC 0920C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1806C (Notice ARC 1683C, IAB 10/15/14), IAB 1/7/15, effective 3/1/15]
[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
[Filed ARC 3718C (Notice ARC 3594C, IAB 1/31/18), IAB 3/28/18, effective 5/2/18]
[Filed ARC 3717C (Notice ARC 3573C, IAB 1/17/18), IAB 3/28/18, effective 7/1/18]
[Filed Emergency After Notice ARC 4052C (Notice ARC 3908C, IAB 8/1/18), IAB 10/10/18, effective 9/12/18]
[Filed ARC 4428C (Notice ARC 4287C, IAB 2/13/19), IAB 5/8/19, effective 7/1/19]
[Filed ARC 4751C (Notice ARC 4600C, IAB 8/14/19), IAB 11/6/19, effective 12/11/19]
[Filed ARC 4900C (Notice ARC 4740C, IAB 11/6/19), IAB 2/12/20, effective 3/18/20]
[Filed ARC 5305C (Notice ARC 5167C, IAB 9/9/20), IAB 12/2/20, effective 2/1/21]
[Filed ARC 5808C (Notice ARC 5619C, IAB 5/19/21), IAB 7/28/21, effective 9/1/21]
[Filed ARC 6226C (Notice ARC 6097C, IAB 12/15/21), IAB 3/9/22, effective 5/1/22]
[Filed ARC 6391C (Notice ARC 6234C, IAB 3/9/22), IAB 6/29/22, effective 9/1/22]

1 Effective date of 81.16(4) delayed 30 days by the Administrative Rules Review Committee at its September 12, 1990, meeting; at the October 9, 1990, meeting the delay was extended to 70 days. Amendment effective 12/1/90 superseded the 70-day delay.
2 Effective date of 81.10(5) delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its November 13, 1990, meeting.
3 Effective date of 81.13(7)“c”(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 14, 1992; delay lifted by the Committee at its meeting held August 11, 1992, effective August 12, 1992.
4 Effective date of 81.6(3), first unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 1993.
At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as ARC 1365B.
OBJECTION

At its meeting held August 11, 1992, the Administrative Rules Review Committee voted to object to the amendments published in ARC 3069A on the grounds the amendments are unreasonable. This filing is published in IAB Vol. XIV No. 253 (06-10-92). It is codified as an amendment to paragraph 441 IAC 81.13(7)“c”(1).

In brief, this filing provides that care facilities shall not employ persons who have been found guilty in a court of law of abusing, neglecting or mistreating facility residents, or who have had a “finding” entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. Additionally, the filing eliminates a previous provision which allowed the Department of Inspections and Appeals some discretion in deciding whether the lifetime ban on employment should be applied.

This language originated in the federal government which mandated that the department adopt these provisions or possibly face sanctions. The Committee does not believe these amendments are an improvement to Iowa’s system and has the following objection. The Committee believes that the amendments published in ARC 3069A are unreasonable because of the inconsistency in the burdens of proof and the levels of procedural safeguards in the two proceedings. A facility employee may either be found guilty in a court of law or have an administrative finding entered into the registry. In either case the result is the same, the employee is permanently banned from further employment in a care facility; however, the two paths to the result are significantly different. The first proceeding is a criminal tribunal in which the burden of proof is “beyond a reasonable doubt.” The second proceeding is a simple administrative hearing in which the burden is “preponderance of the evidence.” The two proceedings also differ in the level of many other due process protections accorded to the individual. A criminal proceeding provides the accused with the opportunity for a trial by jury, competent legal counsel, strict rules of evidence and many procedural protections not present in administrative hearings. It should also be noted that the penalty in this situation—a lifetime ban on employment—is more serious than is usually imposed in contested cases. In licensee discipline cases, a license can be revoked, but the possibility of reinstatement exists; under this new rule no reinstatement is allowed, the facility employee is banned from employment no matter how serious or minor the offense or how far in the past it occurred. Because of the magnitude of this penalty, the Committee believes that the accused should be provided with greater procedural protections than are generally found in administrative hearings.

The Committee also believes this filing is unreasonable because it eliminates the discretion accorded to the Department of Inspections and Appeals to not apply the lifetime ban on employment. Under the previous rule, the department’s discretion in applying the employment ban acted as a safeguard against unjust results. It recognized that a person would make amends for past offenses and earn a second chance. The provision was a genuine improvement in the process; it recognized that flexibility was needed in government decision making and that some decisions should be made on a case-by-case basis. There does not appear to be any rational basis to justify the elimination of this safeguard and, therefore, the Committee believes this action to be unreasonable.

NOTE: The Committee voted to retain this objection at their meeting held February 8, 1993.
CHAPTER 161
IOWA SENIOR LIVING TRUST FUND
Rescinded ARC 6392C, IAB 6/29/22, effective 9/1/22

CHAPTER 162
NURSING FACILITY CONVERSION
AND LONG-TERM CARE SERVICES
DEVELOPMENT GRANTS
Rescinded ARC 6392C, IAB 6/29/22, effective 9/1/22
CHAPTER 164
IOWA HOSPITAL TRUST FUND
Rescinded ARC 6392C, IAB 6/29/22, effective 9/1/22

CHAPTER 165
FAMILY DEVELOPMENT AND SELF-SUFFICIENCY PROGRAM
Rescinded IAB 9/8/10, effective 9/1/10
BARBERS

CHAPTER 21 LICENSURE

CHAPTER 22 INFECTION CONTROL FOR BARBERSHOPS AND BARBER SCHOOLS

CHAPTER 23 BARBER SCHOOLS

CHAPTER 24 CONTINUING EDUCATION FOR BARBERS

CHAPTER 25 DISCIPLINE FOR BARBERS, BARBER INSTRUCTORS, BARBERSHOPS AND BARBER SCHOOLS

CHAPTER 21 LICENSURE

[Prior to 7/29/87, Health Department 470 Ch 152]
[Prior to 2/20/02, see 645—Chapter 20]

645—21.1(158) Definitions. For purposes of these rules, the following definitions shall apply:

“Active license” means a license that is current and has not expired.

“Apprentice” means a person who is at least 16 years of age, who is employed in an apprenticeable occupation, who is a resident of the state of Iowa, and who is registered in Iowa by the Office of Apprenticeship of the United States Department of Labor.

“Apprenticeship program” means a program registered by the Office of Apprenticeship of the United States Department of Labor which includes terms and conditions for the qualification, recruitment, selection, employment, and training of apprentices, including the requirement for a written apprenticeship agreement between an apprentice and an active licensee in an active licensed barbershop as outlined in Iowa Code section 272C.16.

“Apprenticeship sponsor” means an entity operating an apprenticeship program or an entity in whose name an apprenticeship program is being operated, which is registered by or approved by the Office of Apprenticeship of the United States Department of Labor.

“Board” means the board of barbering.

“Examination” means any of the tests used by the board to determine minimum competency prior to the issuance of a barber or barber instructor license.

“Grace period” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“Inactive license” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“License” means any person licensed to practice as a barber in the state of Iowa.

“License expiration date” means June 30 of even-numbered years.

“Licensure by endorsement” means the issuance of an Iowa license to practice as a barber to an applicant who is or has been licensed in another state.

“NIC” means the National-Interstate Council of State Boards of Cosmetology, Inc.

“Reactivate” or “reactivation” means the process as outlined in rule 645—21.16(17A,147,272C) by which an inactive license is restored to active status.

“Reciprocal license” means the issuance of an Iowa license to practice barbering to an applicant who is currently licensed in another state and which state has a mutual agreement to license persons who have the same or similar qualifications to those required in Iowa.

“Reinstatement” means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

“Testing service” means a national testing service selected by the board.
645—21.2(158) Requirements for licensure.

21.2(1) The following criteria shall apply to licensure:

a. Applicants shall complete a board-approved application form. Application forms may be obtained from the board’s website (www.idph.iowa.gov/licensure) or directly from the board office. The application and licensure fees shall be sent to the Board of Barbing, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

b. Applicants shall present proof of completion of the tenth grade or equivalent education. In the event the applicant is a refugee or immigrant from a country where high school records no longer exist, the applicant shall be considered to have met this requirement when the applicant submits an affidavit attesting to the fact that the applicant has met the tenth-grade requirement.

c. Applicants shall provide an official copy of the transcript or diploma sent directly from the school to the board showing proof of completion of training at a barber school licensed by the board. If the applicant graduated from a school that is not licensed by the board, the applicant shall direct the school to provide an official transcript showing completion of a course of study that meets the requirements of rule 645—23.8(158).

d. If the applicant has graduated from an apprenticeship program, the applicant must direct the United States Department of Labor to submit a certificate of completion. If the applicant completed all or part of a barbering apprenticeship training program registered by the Office of Apprenticeship of the United States Department of Labor while committed to the custody of the director of the department of corrections, the applicant shall request the department of corrections to provide an official transcript showing completion of all or part of the apprenticeship program.

e. Applicants shall pass both the NIC theory examination and the NIC practical examination with a score of 70 percent or better on each examination.

f. An applicant shall provide verification of license(s) from every state in which the applicant has been licensed as a barber, sent directly from the state(s) to the Iowa board of barbering office.

g. Applications for a barber license must be received in the board office a minimum of five business days prior to the NIC practical examination.

h. Licensees who were issued their licenses within six months prior to renewal shall not be required to renew their licenses until the renewal month two years later.

i. Incomplete applications that have been on file in the board office for more than two years shall be:

(1) Considered invalid and shall be destroyed; or

(2) Maintained upon written request of the applicant. The applicant is responsible for requesting that the file be maintained.

21.2(2) Foreign-trained barbers shall:

a. Provide an equivalency evaluation of their educational credentials by one of the following: International Educational Research Foundation, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, CA 90231-3665, telephone (310)258-9451, website www.ierf.org or email at info@ierf.org; or World Education Services (WES) at (212)966-6311, electronically at www.wes.org or by writing to WES, P.O. Box 745, Old Chelsea Station, New York, NY 10113-0745. The professional curriculum must be equivalent to that stated in these rules. An applicant shall bear the expense of the curriculum evaluation.

b. Provide a notarized copy of the certificate or diploma awarded to the applicant from a barber school in the country in which the applicant was educated.

c. Receive a final determination from the board regarding the application for licensure.

21.2(3) Requirements for an instructor’s license. Applicants shall:

a. Complete all requirements stated in paragraphs 21.2(1) “a” and “e”;

b. Present proof of graduation from an accredited high school or the equivalent thereof;

c. Be licensed in the state of Iowa as a barber for not less than two years; and

d. Pass both the NIC instructor theory examination and the NIC instructor practical examination with a score of 70 percent or better on each examination.
21.2(4) Instructors who were issued their licenses within six months prior to renewal shall not be required to renew their licenses until the renewal month two years later.

21.2(5) Incomplete applications that have been on file in the board office for more than two years shall be:
   a. Considered invalid and shall be destroyed; or
   b. Maintained upon written request of the applicant. The applicant is responsible for requesting that the file be maintained.

21.2(6) An applicant who meets the requirements for an instructor’s license except for the instructor examinations may apply for a temporary permit to be an instructor. The temporary permit shall be valid for a maximum of six months from the issue date of the permit and shall not be renewable.

21.2(7) Persons licensed under this chapter who provide apprenticeship programs must hold an active license sufficient to provide on-the-job training, must operate an actively licensed establishment and must comply with relevant United States Department of Labor laws and regulations for the operation of an apprenticeship program.

[ARC 7578B, IAB 2/25/09, effective 4/1/09; ARC 8349B, IAB 12/2/09, effective 1/6/10; ARC 5039C, IAB 5/6/20, effective 6/10/20; ARC 6396C, IAB 6/29/22, effective 8/3/22]

645—21.3(158) Examination requirements for barbers and barber instructors.

21.3(1) Theory examination. Applicants shall contact the testing service directly to schedule the computer-based NIC theory examination. The fee for scheduling the written theory examination shall be paid directly to the testing service. This fee is not included in the licensure fee and practical examination fee identified in 645—subrules 5.2(1) and 5.2(4).

21.3(2) Practical examination. Applicants who have completed the application process and passed the NIC theory examination with a score of 70 percent or better shall be eligible to sit for the NIC practical examination administered by the board.
   a. Application, supporting documentation, and licensure and practical examination fees required by the board shall be received in the board office at least five days prior to the scheduled NIC practical examination date.
   b. The board shall send a notice of the date and time of the practical examination to the address on record.
   c. Applicants are required to receive a passing score of 70 percent on the practical examination to be eligible for licensure.
   d. Applicants shall be notified in writing of the result of the practical examination.
   e. Applicants who fail to appear for the practical examination must request in writing or by telephone to reschedule the examination. Examination fees are not refundable, but the rescheduled examination fee may be waived upon the applicant’s showing of good cause for missing the previously scheduled examination. Proof of good cause shall be submitted to the board office with the request to reschedule the examination. The applicant shall be required to pay the reexamination fee if the applicant does not appear for the subsequent examination.
   f. Persons who do not attain the passing score may reapply to take the practical examination. The examination fee cannot be refunded, and the applicant shall be required to pay the reexamination fee.

[ARC 7578B, IAB 2/25/09, effective 4/1/09; ARC 8349B, IAB 12/2/09, effective 1/6/10]

645—21.4 Reserved.

645—21.5(158) Licensure by endorsement. The board may issue a license by endorsement to any applicant from the District of Columbia or another state, territory, province or foreign country who has held an active license under the laws of another jurisdiction for at least 12 months during the past 24 months and who:

21.5(1) Submits to the board a completed application and pays the licensure fee specified in 645—subrule 5.2(1).
21.5(2) Provides verification of license(s) from every state in which the applicant has been licensed as a barber, sent directly from the state(s) to the Iowa board of barbering office. Web-based verification may be substituted for verification direct from the jurisdiction’s board office if the verification provides:

- a. Licensee’s name;
- b. Date of initial licensure;
- c. Current licensure status; and
- d. Any disciplinary action taken against the license.

21.5(3) Beginning August 1, 2010, completes one hour of Iowa barbering laws and administrative rules and sanitation.

21.5(4) Passes a national written and practical examination.

21.5(5) A person who is licensed in another jurisdiction but who is unable to satisfy the requirements of licensure by endorsement may apply for licensure by verification, if eligible, in accordance with rule 645—19.1(272C).

[ARC 7578B, IAB 2/25/09, effective 4/1/09; ARC 8349B, IAB 12/2/09, effective 1/6/10; ARC 5754C, IAB 7/14/21, effective 8/18/21]

645—21.6 Reserved.

645—21.7(158) Temporary permits to practice barbering. An applicant must meet the following requirements:

1. The applicant is applying for initial licensure and is not licensed in another state.
2. The applicant has met the requirements for licensure except for passing the examinations required by the board. The temporary permit is valid from the date the application is approved for a maximum of six months and shall not be renewable.

[ARC 8349B, IAB 12/2/09, effective 1/6/10]

645—21.8(158) Demonstrator’s permit. The board may issue a demonstrator’s permit to a licensed barber for the purpose of demonstrating barbering to the public. The following criteria apply to the demonstrator’s permit:

1. A demonstrator’s permit shall be valid for a barbershop, person or an event. The location, purpose and duration shall be stated on the permit.
2. A demonstrator’s permit shall be valid for no more than 10 days.
3. A completed application shall be submitted on a form provided by the board at least 30 days in advance of the intended use dates.
4. An application fee shall be submitted as set forth in these rules.
5. No more than four permits shall be issued to any applicant during a calendar year.

645—21.9(158) License renewal.

21.9(1) The biennial license renewal period for a license to practice barbering shall begin on July 1 of each even-numbered year and end on June 30 of each even-numbered year. All licensees shall renew on a biennial basis. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

21.9(2) A licensee seeking renewal shall:

- a. Meet the continuing education requirements of rule 645—24.2(158). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and
- b. Submit the completed renewal application and renewal fee before the license expiration date.
- c. Persons licensed to practice as barbers shall keep their renewal licenses displayed in a conspicuous public place at the primary site of practice.
- d. Individuals who were issued a license within six months of the license renewal date will not be required to renew their licenses until the next renewal two years later.

21.9(3) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in 645—subrule
5.2(10). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period. 

21.9(4) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

21.9(5) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as a barber in Iowa until the license is reactivated. A licensee who practices as a barber in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

[ARC 7578B, IAB 2/25/09, effective 4/1/09; ARC 1680C, IAB 10/15/14, effective 11/19/14; ARC 5754C, IAB 7/14/21, effective 8/18/21]

645—21.10 Reserved.

645—21.11(158) Requirements for a barbershop license.

21.11(1) A barbershop shall not operate unless the owner of the barbershop possesses a current barbershop license issued by the board. The following criteria shall apply to licensure:

a. The owner shall complete a board-approved application form. Application forms may be obtained from the board’s website (www.idph.iowa.gov/licensure), or directly from the board office. The application and fee shall be submitted to the Board of Barbering, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

b. The barbershop shall meet the requirements for sanitary conditions established in 645—Chapter 22.

c. A barbershop license may be for a stationary barbershop or a mobile barbershop.

(1) Stationary barbershop. A stationary barbershop license shall be issued for a specific location. A change in location or site of a stationary barbershop shall result in the cancellation of the existing license and necessitate application for a new license and payment of the fee required by 645—subrule 5.2(8). A change of address without change of actual location shall not be construed as a new site.

(2) Mobile barbershop. A mobile barbershop license shall be issued for a permanent physical address. The licensee is required to provide a permanent physical address for board correspondence. A mobile barbershop may operate in a legal parking spot or on private property, with the permission of the owner or the owner’s designee, anywhere in the state of Iowa provided the mobile barbershop is operating in compliance with applicable federal and state transportation, environmental, and sanitary regulations, including those herein.

(3) Barbershop owner’s contact information. The listed owner of either a stationary or mobile barbershop must update the board within 30 days of a change in contact information, which includes telephone number, email address, and mailing address.

d. A barbershop license is not transferable. A change in ownership of a barbershop shall result in the cancellation of the existing license and necessitate application for a new license and payment of the fee required by 645—subrule 5.2(8).

e. A change in the name of a barbershop shall be reported to the board within 30 days of the name change.

f. Upon closure of a barbershop, the barbershop license shall be submitted to the board office within 30 days.

g. A barbershop that was issued a license within six months prior to renewal shall not be required to renew the license until the renewal month two years later.

21.11(2) Incomplete applications that have been on file in the board office for more than two years shall be:

a. Considered invalid and shall be destroyed; or
b. Maintained upon written request of the candidate. The candidate is responsible for requesting that the file be maintained.
[ARC 7578B, IAB 2/25/09, effective 4/1/09; ARC 5686C, IAB 6/16/21, effective 7/21/21]

645—21.12(158) Barbershop license renewal.

21.12(1) The biennial license renewal period for a barbershop license shall begin on July 1 of each even-numbered year and end on June 30 of the next even-numbered year.

21.12(2) Failure to receive the renewal application from the board shall not relieve the barbershop of the obligation to pay the biennial renewal fee on or before the renewal date.

21.12(3) The completed application and renewal fee shall be submitted to the board office before the license expiration date.

21.12(4) The barbershop shall be in full compliance with this chapter and 645—Chapter 22 to be eligible for license renewal.

21.12(5) A barbershop that is issued an initial license within six months prior to the renewal date will not be required to renew the license until the next renewal two years later.

21.12(6) Barbershop license late renewal. If the renewal fee and renewal application are received within 30 days after the license renewal expiration date, the late fee for failure to renew before expiration shall be charged.

21.12(7) Inactive barbershop license. If the renewal application and fee are not postmarked within 30 days after the license expiration date, the barbershop license is inactive. To reactivate a barbershop license, the reactivation application and fee shall be submitted to the board office.

[ARC 7578B, IAB 2/25/09, effective 4/1/09; ARC 1680C, IAB 10/15/14, effective 11/19/14; ARC 5754C, IAB 7/14/21, effective 8/18/21]

645—21.13 to 21.15 Reserved.

645—21.16(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

21.16(1) Submit a reactivation application on a form provided by the board.

21.16(2) Pay the reactivation fee that is due as specified in 645—subrule 5.2(11).

21.16(3) Provide verification of current competence to practice as a barber by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

   (1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction’s board office if the verification includes:
      1. Licensee’s name;
      2. Date of initial licensure;
      3. Current licensure status; and
      4. Any disciplinary action taken against the license; and
   (2) Verification of completion of three hours of continuing education that meet the continuing education standards defined in rule 645—24.3(158,272C) within two years of application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

   (1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction’s board office if the verification includes:
      1. Licensee’s name;
      2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and
   (2) Verification of completion of three hours of continuing education that meet the continuing education standards defined in rule 645—24.3(158,272C) within two years of application for reactivation; and
(3) Verification of passing the examinations required by the board within one year immediately prior to reactivation if the applicant does not have a current license and has not been in active practice in the United States during the past five years.

21.16(4) Licensees who are barber instructors shall obtain an additional four hours of continuing education in teaching methodology.

[ARC 7578B, IAB 2/25/09, effective 4/1/09; ARC 8349B, IAB 12/2/09, effective 1/6/10; ARC 2722C, IAB 9/28/16, effective 11/2/16]

645—21.17(17A,147,272C) Reactivation of a barbershop license. To apply for reactivation of an inactive license, a licensee shall:

    21.17(1) Submit a reactivation application on a form provided by the board.
    21.17(2) Pay the reactivation fee that is due as specified in 645—subrule 5.2(12).
    21.17(3) Meet the requirements for sanitary conditions established in 645—Chapter 22.

[ARC 7578B, IAB 2/25/09, effective 4/1/09]

645—21.18(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—21.16(17A,147,272C) prior to practicing as a barber in this state.

[ARC 7578B, IAB 2/25/09, effective 4/1/09]

645—21.19(158) Mobile barbershops. A mobile home, motor home, trailer, or other recreational vehicle may be used as a mobile barbershop if it complies with the following:

    21.19(1) The owner shall possess a current mobile barbershop license issued by the board.
    21.19(2) The owner shall complete a board-approved application.
    21.19(3) The mobile barbershop’s owner’s telephone number, email address, and permanent address must be included on the mobile barbershop’s application for licensure and must be updated and accurate.
    21.19(4) No service may be performed on a client in a moving vehicle. Services shall be performed in a mobile barbershop that is parked in a legal parking spot.
    21.19(5) Mobile barbershops must provide:
        a. A supply of hot and cold water;
        b. Adequate lighting;
        c. A floor surface in the service area that is nonabsorbent and easily cleanable;
        d. Work surfaces that are easily cleaned;
        e. Cabinets secured with safety catches wherein all chemicals shall be stored when the vehicle is moving;
        f. A first-aid kit that includes adhesive dressing, gauze and antiseptic, tape, triple antibiotics, eyewash, and gloves.
    21.19(6) Mobile barbershops must comply with all rules in 645—Chapter 22, Infection Control for Barbershops and Barber Schools, except rules 645—22.5(158) through 645—22.7(158).

[ARC 5866C, IAB 6/16/21, effective 7/21/21]

These rules are intended to implement Iowa Code chapters 272C and 158.

[Filed 7/11/67]
[Filed 8/5/77, Notice 6/1/77—published 8/24/77, effective 10/1/77]
[Filed 4/28/78, Notice 11/30/77—published 5/17/78, effective 6/21/78]
[Filed 1/18/79, Notice 10/18/78—published 2/7/79, effective 4/1/79]
[Filed 5/5/80, Notice 2/20/80—published 5/28/80, effective 7/7/80]
[Filed 11/4/80, Notice 9/3/80—published 11/26/80, effective 1/1/81]
[Filed 5/22/81, Notice 2/18/81—published 6/10/81, effective 7/17/81]
[Filed 2/12/82, Notice 12/23/81—published 3/3/82, effective 4/8/82]
[Filed 10/6/83, Notice 8/17/83—published 10/26/83, effective 11/30/83]
[Filed 10/6/83, Notice 8/3/83—published 10/26/83, effective 11/30/83]
[Filed 7/27/84, Notice 5/23/84—published 8/15/84, effective 9/19/84]
[Filed emergency 8/31/84—published 9/26/84, effective 8/31/84]
[Filed 11/15/84, Notice 9/12/84—published 12/5/84, effective 1/9/85]
[Filed 9/4/85, Notice 5/22/85—published 9/25/85, effective 10/30/85]
[Filed 9/5/85, Notice 7/17/85—published 9/25/85, effective 10/30/85]
[Filed 2/20/86, Notice 1/15/86—published 3/12/86, effective 4/16/86]
[Filed 8/22/86, Notice 6/18/86—published 9/10/86, effective 11/5/86]
[Filed emergency 7/10/87—published 7/29/87, effective 7/10/87]
[Filed 11/17/88, Notice 8/24/88—published 12/14/88, effective 1/18/89]
[Filed 8/3/90, Notice 5/30/90—published 8/22/90, effective 9/26/90]
[Filed 11/9/90, Notice 8/22/90—published 11/28/90, effective 1/2/91]
[Filed 8/1/91, Notice 6/12/91—published 8/21/91, effective 9/25/91]
[Filed 11/8/91, Notice 9/4/91—published 11/27/91, effective 1/1/92]¹
[Filed 7/31/92, Notice 4/15/92—published 8/19/92, effective 10/1/92]
[Filed 11/16/92, Notice 7/8/92—published 12/9/92, effective 1/13/93]
[Filed 1/29/93, Notice 10/14/92—published 2/17/93, effective 4/7/93]
[Filed 1/29/93, Notice 12/9/92—published 2/17/93, effective 4/7/93]
[Filed 5/2/97, Notice 3/12/97—published 5/21/97, effective 6/25/97]
[Filed 11/24/99, Notice 8/11/99—published 12/15/99, effective 1/19/00]
[Filed 11/9/00, Notice 8/23/00—published 11/29/00, effective 1/3/01]
[Filed 2/1/02, Notice 11/28/01—published 2/20/02, effective 3/27/02]
[Filed 1/30/03, Notice 11/27/02—published 2/19/03, effective 3/26/03]
[Filed 11/6/03, Notice 8/20/03—published 11/26/03, effective 12/31/03]
[Filed 7/26/05, Notice 5/25/05—published 8/17/05, effective 9/21/05]⁰
[Filed 2/1/06, Notice 11/23/05—published 3/1/06, effective 4/5/06]
[Filed 7/26/06, Notice 5/24/06—published 8/16/06, effective 9/20/06]
[Filed 8/1/07, Notice 5/23/07—published 8/29/07, effective 10/3/07]
[Filed ARC 7578B (Notice ARC 7401B, IAB 12/3/08), IAB 2/25/09, effective 4/1/09]
[Filed ARC 8349B (Notice ARC 8085B, IAB 8/26/09), IAB 12/2/09, effective 1/6/10]
[Filed ARC 1680C (Notice ARC 1584C, IAB 8/20/14), IAB 10/15/14, effective 11/19/14]
[Filed ARC 2722C (Notice ARC 2670C, IAB 8/3/16), IAB 9/28/16, effective 11/2/16]
[Filed ARC 5039C (Notice ARC 4860C, IAB 1/15/20), IAB 5/6/20, effective 6/10/20]
[Filed ARC 5686C (Notice ARC 5557C, IAB 4/7/21), IAB 6/16/21, effective 7/21/21]
[Filed ARC 5754C (Notice ARC 5450C, IAB 2/24/21), IAB 7/14/21, effective 8/18/21]
[Filed ARC 6396C (Notice ARC 6259C, IAB 3/23/22), IAB 6/29/22, effective 8/3/22]

⁰ Two or more ARCs
¹ See Public Health Department[641], IAB
² Effective date of rule 567—20.10(158) delayed 70 days by the Administrative Rules Review Committee at its meeting held
CHAPTER 22
INFECTION CONTROL FOR BARBERSHOPS AND BARBER SCHOOLS
[Prior to 7/29/87, Health Department[470] Ch 153]
[Prior to 2/20/02, see 645—Chapter 21]

645—22.1(158) Definitions.

“Apprentice” means a person who is at least 16 years of age, who is employed in an apprenticeable occupation, who is a resident of the state of Iowa, and who is registered in Iowa by the Office of Apprenticeship of the United States Department of Labor.

“Apprenticeship instructor” means an instructor who delivers theory instruction in apprenticeship programs and who must meet the United States Department of Labor’s requirements for career and technical instructors. It is recommended that all apprenticeship instructors have training in teaching techniques and adult learning styles.

“Apprenticeship program” means a program registered by the Office of Apprenticeship of the United States Department of Labor which includes terms and conditions for the qualification, recruitment, selection, employment, and training of apprentices, including the requirement for a written apprenticeship agreement between an apprentice and an active licensee in an active licensed barbershop as outlined in Iowa Code section 272C.16.

“Apprenticeship sponsor” means an entity operating an apprenticeship program or an entity in whose name an apprenticeship program is being operated, which is registered by or approved by the Office of Apprenticeship of the United States Department of Labor.

“Cleaning” refers to removing visible debris and disposable parts, washing the surface or item with water and soap or detergent, rinsing the surface or item thoroughly and drying the surface or item. Cleaning must occur before disinfection can begin.

“Disinfectant” means an EPA-registered bactericidal, virucidal, fungicidal, pseudomonacidal chemical solution, spray or wipe that is effective against HIV-1 and human hepatitis B virus and is intended to destroy or irreversibly inactivate specific viruses, bacteria, or pathogenic fungi, but not necessarily their spores, on nonporous items and surfaces.

“Disinfection” means the procedure that kills pathogenic microorganisms, but not necessarily their spores.

“Dispensary” means a separate physical location or area in a barbershop or school to be used for the storing and dispensing of supplies and cleaning and disinfecting of all implements. The dispensary is where products, chemicals and disinfectants are prepared, measured, mixed, portioned, and disposed of.

“FDA” means the federal Food and Drug Administration.

“Germicide” means an agent that destroys germs.

“Nonporous” means that a material has no pores and does not allow liquid or air to be absorbed or pass through. Common nonporous materials include glass, metal and plastic products.

“On-the-job trainer” means the individual providing instruction and supervision of the apprenticeship program practical hours. This individual must be a licensee of the board in the discipline for which they are training, and the training must occur in a licensed establishment.

“Porous” means that a material has minute spaces or holes that allow liquid or air to be absorbed or pass through. Common porous materials include pumice stone, wood, paper and cardboard products.

“Sterilization” means the procedure that kills all microorganisms, including their spores.

“Universal precautions” means practices consistently used to prevent exposure to blood-borne pathogens and the transmission of disease.

“Wash hands” means the process of thoroughly washing hands and the exposed portions of the arms up to the elbow with soap or detergent and water and drying with a single-use towel or air dryer. Bar soap shall not be considered to be a sanitizing agent.

[ARC 3444C, IAB 11/8/17, effective 12/13/17; ARC 6396C, IAB 6/29/22, effective 8/3/22]

645—22.2(158) Infection control rules and inspection report. Upon request, the licensee shall make Chapter 22, Infection Control for Barbershops and Barber Schools, and the most recent inspection report
available to the board, agents of the board, all persons employed or studying in a barbershop or school, and the general public.
[ARC 3444C, IAB 11/8/17, effective 12/13/17]

645—22.3(147) Display requirements for barbershops.

22.3(1) Every barbershop shall have a sign visible outside the entrance designating the place of business.

22.3(2) The most current barbershop license renewal card shall be posted in the barbershop front entrance area at eye level, so that it is visible, to provide the public a full, unobstructed view of the license. Photocopies and electronic copies are not acceptable.

22.3(3) The most current license renewal card for each licensee working in the barbershop shall be posted in the barbershop front entrance area at eye level, so that it is visible, to provide the public a full, unobstructed view of the license. Photocopies and electronic copies are not acceptable.

22.3(4) If the licensee works in more than one barbershop, the current renewal card shall be posted in the primary place of practice, and the licensee shall have the current wallet card in the licensee’s possession.

22.3(5) Each licensee and apprentice shall have a valid U.S. government-issued photo ID to provide to an agent of the board upon request as proof of identity.

22.3(6) A sign shall be clearly displayed in the entrance of the barbershop that indicates in prominent lettering that an apprentice is employed and may perform services under the supervision of a licensed apprenticeship supervisor.

[ARC 7578B, IAB 2/25/09, effective 4/1/09; ARC 3444C, IAB 11/8/17, effective 12/13/17; ARC 6396C, IAB 6/29/22, effective 8/3/22]

645—22.4(158) Responsibilities of barbershop owner and supervisor.

22.4(1) Each barbershop owner shall ensure that individuals who provide barbering or cosmetology services hold a current and valid Iowa license or temporary work permit to practice barbering or cosmetology.

22.4(2) Each owner shall ensure that all employees observe all applicable rules.

22.4(3) Each barbershop owner who provides apprenticeship programs must ensure on-the-job trainers are licensed and operating in an actively licensed establishment and comply with relevant United States Department of Labor laws and regulations for the operation of an apprenticeship program.

[ARC 7578B, IAB 2/25/09, effective 4/1/09; ARC 6396C, IAB 6/29/22, effective 8/3/22]

645—22.5(158) Building standards. Barbershops and schools shall provide:

1. A separate area to be used as a reception area;
2. A supply of hot and cold running water and toilet facilities;
3. A supply of safe drinking water;
4. Hand-washing facilities;
5. Adequate lighting;
6. A floor surface in the service area that is nonabsorbent and easily cleanable;
7. A minimum of one washbasin or lavatory for every two barber chairs in use. The washbasins or lavatories shall be readily accessible to the operator of each barber chair;
8. Work surfaces that are easily cleaned;
9. A dispensary; and
10. A complete first-aid kit in a readily accessible location on the premises. At a minimum, the first-aid kit must include adhesive dressing, gauze and antiseptic, tape, triple antibiotics, eyewash, and gloves.

[ARC 3444C, IAB 11/8/17, effective 12/13/17]

645—22.6(158) Barbershops in residential buildings.

22.6(1) A barbershop located in a residential building shall comply with all requirements in rule 645—22.5(158).
22.6(2) A separate entrance shall be maintained for barbershops in residential buildings. An exception is that an entrance may allow passage through a nonliving area of the residence, i.e., hall, garage or stairway. Any door leading directly from the licensed barbershop to any portion of the living area of the residence shall be closed at all times during business hours.

645—22.7(158) Barbershops adjacent to other businesses. A barbershop operated adjacent to any other business shall be separated by at least a partial partition. When the barbershop is operated immediately adjacent to a business where food is handled, the establishment shall be entirely separated and any doors between the barbershop and the business shall be rendered unusable except in an emergency.

645—22.8(142D,158) Smoking. Barbershops licensed by the board shall comply with the smokefree air Act as found in Iowa Code chapter 142D.

645—22.9(158) Personal cleanliness.

22.9(1) All licensees or students that engage in serving the public shall be neat and clean in person and attire.

22.9(2) All licensees performing services shall thoroughly wash their hands with soap and water or any equally effective cleansing agent immediately before serving each client.

645—22.10(158) Universal protocols. All licensees and students shall practice universal precautions consistently by observing the following.

22.10(1) Students and licensees shall thoroughly wash hands after smoking, eating, or using the restroom and before providing services to each client. Hand sanitizers or gloves are not an acceptable substitute for handwashing.

22.10(2) Every barbershop shall have a biohazard sharps container for disposing of used needles, razor blades and other sharp instruments. These containers shall be located as close to the use area as is practical. These containers shall not be filled above the designated “fill line” and shall be disposed of in accordance with guidelines issued by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

22.10(3) Licensees and students shall wear disposable gloves or may refuse to provide the service when encountering clients with open sores. Gloves shall only be used on a single client and shall be disposed of after the client’s service. Anytime gloves are used during a service, licensees and students shall wash hands both before gloves are worn and after they are removed.

22.10(4) A licensee or student shall refrain from all direct client care and from handling client-care equipment if the licensee or student has open sores that cannot be effectively covered.

22.10(5) Instruments and implements shall be disinfected pursuant to rule 645—22.12(158).

22.10(6) Instruments and supplies that have been used on a client or soiled in any manner shall be placed in the proper receptacles clearly labeled “used.” All used items shall be kept separate from items that are disinfected and ready for use.

22.10(7) Disinfectant solution shall be stored in the dispensary.

645—22.11(158) Minimum equipment and supplies. Barbershops and barber schools shall provide:

1. At least one covered waste receptacle for the disposal of all waste, including hair;
2. Receptacles to hold all soiled towels and capes;
3. Clean, closed cabinets or drawers to hold all clean towels;
4. Disinfectant solution kept in the dispensary, and at each workstation at the discretion of the individual licensee or barbershop owner; and
5. A mechanical paper container and clean shaving paper or clean towel for each barber chair headrest.

[ARC 7578B, IAB 2/25/09, effective 4/1/09; ARC 3444C, IAB 11/8/17, effective 12/13/17]
645—22.12(158) Disinfection and sterilizing instruments and equipment. All nonporous tools and implements must be either disinfected or sterilized according to the requirements of this rule before use upon a client in schools and barbershops.

22.12(1) Disinfection.
   a. Nonporous tools and implements.
      (1) Immersion method. After each use, all immersible nonporous tools and implements shall be disinfected by cleaning the tools and implements followed by complete immersion in a disinfectant. Disinfectant solutions shall be mixed according to manufacturer label instructions. The manufacturer’s listed contact time for effectively eliminating all pathogens listed shall be adhered to at all times.
      (2) Nonimmersion method. After each use, any nonporous item that cannot be immersed in a disinfectant shall be cleaned with soap or detergent and water to remove all organic material and then sprayed or wiped with disinfectant. Minimum disinfectant contact time as listed on the manufacturer’s label shall be followed. Nonimmersible tools and implements include, but are not limited to, scissors, trimmers, clippers, handles of hair dryers and curling/flat irons.
   b. Disinfected implements shall be stored in a disinfected, dry, covered container and shall be isolated from contaminants. The container shall be disinfected at least once each week and whenever the disinfectant solutions are visibly dirty.
   c. Disinfectant solutions shall be changed as instructed on the solution’s manufacturer label or whenever the disinfectant solutions are visibly dirty.

22.12(2) Sterilization. UV light boxes are prohibited and are not an acceptable method of sterilization.
   a. Tools and implements may be sterilized by one of the following methods:
      (1) Steam sterilizer, registered and listed with the FDA and used according to the manufacturer’s instructions. If steam sterilization, moist heat, is utilized, heat exposure shall be at a minimum of 121°C/250°F for at least 30 minutes;
      (2) Dry heat sterilizer, registered and listed with the FDA and used according to the manufacturer’s instructions. If dry heat sterilization is utilized, heat exposure shall be at a minimum of 171°C/340°F for at least 60 minutes;
      (3) Autoclave sterilization equipment, calibrated to ensure that it reaches the temperature required by the manufacturer’s instructions. If autoclave sterilization equipment is utilized, spore testing by a contracted independent laboratory shall be performed at least every 30 days. If a positive spore test is received, the autoclave may not be used until a negative spore test is received. The barbershop must maintain a log of each autoclave use, all testing samples and results, and a maintenance log of all maintenance performed on the device. Maintenance shall be performed according to the manufacturer’s instructions. The barbershop must have available for inspection the autoclave maintenance log for the most recent 12 months; or
      (4) Chemical sterilization with a hospital grade liquid which, if used, shall be used according to the directions on the label. When chemical sterilization is used, items shall be fully submerged for at least 10 minutes.
   b. Sterilization equipment shall be maintained in working order. The equipment shall be checked at least monthly and calibrated to ensure that it reaches the temperature required by the manufacturer’s instructions.

[ARC 3444C, IAB 11/8/17, effective 12/13/17]


645—22.14(158) Porous instruments and supplies that cannot be disinfected. Porous instruments and supplies that come into direct contact with a client and cannot be disinfected are single-use items and shall be disposed of in a closed waste receptacle immediately after use. These instruments and supplies include, but are not limited to, cotton pads, sponges, emery boards, and neck strips.

[ARC 3444C, IAB 11/8/17, effective 12/13/17]
645—22.15(158) **Semisolids, dusters, and styptics.**

22.15(1) Creams and other semisolid substances used for clients must be kept in closed, labeled containers. All creams and other semisolid substances shall be removed from containers with a clean and disinfected applicator. Applicators made of a washable, nonabsorbent material shall be cleaned and disinfected before being used on a client and shall only be dipped into the container one time before being cleaned and disinfected again. Applicators made of wood shall be discarded after a single dip, which would be one use.

22.15(2) The use of a styptic pencil is strictly prohibited; its presence in the workplace shall be prima facie evidence of its use. Any material used to stop the flow of blood shall be used in liquid or powder form.

22.15(3) Nail buffers are for individual use and may not be used for more than one client. Presence of these articles in the workplace shall be prima facie evidence of use.

22.15(4) All fluids, semifluids and powders must be dispensed with an applicator or from a shaker, dispenser pump, or spray-type container.

22.15(5) Neck dusters, brushes, and common shaving mugs and soap shall not be used in any barbershop or barber school.

[ARC 3444C, IAB 11/8/17, effective 12/13/17]

645—22.16(158) **Blood exposure procedures.**

22.16(1) If a student or licensee injures oneself, the following steps shall be taken before the student or licensee returns to service:

a. Stop service.

b. Clean the injured area by washing the area with soap and water. Use antiseptic or ointment as appropriate.

c. In the case of mucous membrane exposure, wash or rinse the affected area with plenty of water.

d. Cover the injury with the appropriate dressing.

e. Clean the client and station as necessary. First, remove all visible debris and then clean the client with an antiseptic that is appropriate for the skin and clean the station with disinfectant.

f. Bag any blood-soiled porous articles and dispose of articles in the trash.

g. Wash and disinfect all nonporous items.

h. Wash hands before returning to service.

22.16(2) If a client injury occurs, the following steps shall be taken:

a. Stop service.

b. Glove hands of students or licensees.

c. Clean injured area and use antiseptic or ointment as appropriate.

d. Cover the injury with the appropriate dressing to prevent further blood exposure.

e. Clean station by removing all visible debris and using disinfectant that is appropriate for the soiled surface.

f. Bag any blood-soiled porous articles and dispose of articles in the trash.

g. Wash and disinfect all nonporous items.

h. Wash hands before returning to service.

[ARC 3444C, IAB 11/8/17, effective 12/13/17]

645—22.17(158) **Prohibited hazardous substances and use of products.** No barbershop or barber school shall have on the premises products containing substances which have been banned or otherwise deemed hazardous or deleterious by the FDA for use in cosmetic products. Prohibited products include, but are not limited to, any product containing liquid methyl methacrylate monomer and methylene chloride. No product shall be used in a manner that is not approved by the FDA. The presence of the product in a barbershop or barber school is prima facie evidence of that product’s use in the barbershop or barber school.

645—22.18(158) **Proper protection of neck.** A shampoo apron, haircloth, or similar article shall not be placed directly against the neck of the client but shall be kept from direct contact with the client by means
of a paper neckband or clean towel. A neckband of paper shall not be used more than once. Towels or cloth neckbands shall not be used more than once without proper laundering.

645—22.19(158) Proper laundering and storage. All cloth towels and similar items shall be laundered in a washing machine with laundry detergent used according to manufacturer’s directions. All linens shall be dried until hot to the touch. No moisture shall be left in laundered items. A clean, closed storage area shall be provided for clean towels and linen, and a covered hamper or receptacle marked “used” shall be provided for all soiled towels, robes and linens.

[ARC 3444C, IAB 11/8/17, effective 12/13/17]

645—22.20(158) Pets. Dogs (except dogs providing assistance to persons with physical disabilities), cats, birds, or other animals shall not be permitted in a barbershop or barber school. This rule does not apply to fish in an aquarium provided the aquarium is maintained in a sanitary condition.

645—22.21(158) Records. Client records and appointment records for chemical services shall be maintained for a period of no less than three years following the last date of entry. Proper safeguards shall be provided to ensure the safety of these records from destructive elements.

These rules are intended to implement Iowa Code chapter 158.

[Filed 8/10/56; amended 7/11/67]
[Filed 9/2/77, Notice 7/13/77—published 9/21/77, effective 11/1/77]
[Filed 2/25/78, Notice 2/7/79—published 5/21/79, effective 7/1/79]
[Filed 9/20/84, Notice 5/23/84—published 10/10/84, effective 11/14/84]
[Filed 8/22/86, Notice 6/18/86—published 9/10/86, effective 11/5/86]
[Filed 1/15/87, Notice 11/19/86—published 2/11/87, effective 3/18/87]
[Filed emergency 7/10/87—published 7/29/87, effective 7/10/87]
[Filed 2/1/02, Notice 2/28/01—published 2/20/02, effective 3/27/02]
[Filed 11/6/02, Notice 8/21/02—published 11/27/02, effective 1/1/03]
[Filed 11/6/03, Notice 8/20/03—published 11/26/03, effective 12/31/03]
[Filed ARC 7578B (Notice ARC 7401B, IAB 12/3/08), IAB 2/25/09, effective 4/1/09]
[Filed ARC 3444C (Notice ARC 3021C, IAB 4/12/17), IAB 11/8/17, effective 12/13/17]
[Filed ARC 6396C (Notice ARC 6259C, IAB 3/23/22), IAB 6/29/22, effective 8/3/22]
COSMETOLOGISTS

CHAPTER 60 LICENSURE OF COSMETOLOGISTS, ELECTROLOGISTS, ESTHETICIANS, MANICURISTS, NAIL TECHNOLOGISTS, AND INSTRUCTORS OF COSMETOLOGY ARTS AND SCIENCES

CHAPTER 61 LICENSURE OF SALONS AND SCHOOLS OF COSMETOLOGY ARTS AND SCIENCES

CHAPTER 62 RESERVED

CHAPTER 63 SANITATION FOR SALONS AND SCHOOLS OF COSMETOLOGY ARTS AND SCIENCES

CHAPTER 64 CONTINUING EDUCATION FOR COSMETOLOGY ARTS AND SCIENCES

CHAPTER 65 DISCIPLINE FOR COSMETOLOGY ARTS AND SCIENCES LICENSEES, INSTRUCTORS, SALONS, AND SCHOOLS

CHAPTER 60 LICENSURE OF COSMETOLOGISTS, ELECTROLOGISTS, ESTHETICIANS, MANICURISTS, NAIL TECHNOLOGISTS, AND INSTRUCTORS OF COSMETOLOGY ARTS AND SCIENCES

[Prior to 7/29/87, Health Department [470] Chs 149, 150]

645—60.1(157) Definitions. For purposes of these rules, the following definitions shall apply:

“Active license” means a license that is current and has not expired.

“Apprentice” means a person who is at least 16 years of age, who is employed in an apprenticeable occupation, who is a resident of the state of Iowa, and who is registered in Iowa by the Office of Apprenticeship of the United States Department of Labor.

“Apprenticeship program” means a program registered by the Office of Apprenticeship of the United States Department of Labor, which includes terms and conditions for the qualification, recruitment, selection, employment, and training of apprentices, including the requirement for a written apprenticeship agreement between an apprentice and an active licensee in an active licensed salon.

“Board” means the board of cosmetology arts and sciences.

“Certified laser product” means a product which is certified by a manufacturer pursuant to the requirements of 21 Code of Federal Regulations (CFR) Part 1040.

“Chemical exfoliation” means the removal of surface epidermal cells of the skin by using only non-medical-strength cosmetic preparations consistent with labeled instructions and as specified by rule. This procedure is not intended to elicit viable epidermal or dermal wounding, injury, or destruction.

“Core curriculum” means the basic core life sciences curriculum that is required for completion of any course of study of the cosmetology arts and sciences except for manicuring.

“Cosmetology arts and sciences” means any or all of the following disciplines performed with or without compensation by a licensee: cosmetology, electrology, esthetics, nail technology and manicuring.

“Depilatory” means an agent used for the temporary removal of superfluous hair by dissolving it at the epidermal surface.

“Examination” means any of the tests used to determine minimum competency prior to the issuance of a cosmetology arts and sciences license.

“Exfoliation” means the process whereby the superficial epidermal cells are removed from the skin.

“General supervision” means the supervising physician is not onsite for laser procedures or use of an intense pulsed light device for hair removal conducted on minors, but is available for direct communication, either in person or by telephone, radio, radiotelephone, television, or similar means.

“Grace period” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“Inactive license” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“Intense pulsed light device” means a device that uses incoherent light to destroy the vein of the hair bulb.
“Laser” means light amplification by the stimulated emission of radiation.

“Licensee” means any person or entity licensed to practice pursuant to Iowa Code chapter 157 and 645—Chapters 60 to 65, Iowa Administrative Code.

“Licensure by endorsement” means the issuance of an Iowa license to practice cosmetology to an applicant who is or has been licensed in another state for 12 months during the last 24 months.

“Mechanical exfoliation” means the physical removal of surface epidermal cells by means that include but are not limited to brushing machines, granulated scrubs, peel-off masques, peeling creams or drying preparations that are rubbed off, and microdermabrasion.

“Mentor” means a licensee providing guidance in a mentoring program.

“Mentoring” means a program allowing students to experience cosmetology arts and sciences in a licensed salon under the guidance of a mentor.

“Microdermabrasion” means mechanical exfoliation using an abrasive material or apparatus to remove surface epidermal cells with a machine which is specified by rule.

“Minor” means an unmarried person who is under the age of 18 years.

“NIC” means the National-Interstate Council of State Boards of Cosmetology, Inc.

“Pedicuring” means the practice of cleaning, shaping or polishing the toenails.

“Practice discipline” means the practice of electrology, esthetics, nail technology, manicuring or cosmetology as recognized by the board of cosmetology arts and sciences.

“Reactivate” or “reactivation” means the process as outlined in rule 645—60.17(17A,147,272C) by which an inactive license is restored to active status.

“Reciprocal license” means the issuance of an Iowa license to practice cosmetology to an applicant who is currently licensed in another state and which state has a mutual agreement to license persons who have the same or similar qualifications to those required in Iowa.

“Reinstatement” means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

“Testing service” means a national testing service selected by the board.

[ARC 8515B, IAB 2/10/10, effective 3/17/10; ARC 6376C, IAB 6/29/22, effective 8/3/22]

645—60.2(157) Requirements for licensure.

60.2(1) Requirements for licensure. All persons providing services in one or more cosmetology arts and sciences disciplines shall hold a license issued by the board. The applicant shall:

a. Submit a completed application for licensure.

b. Direct the educational program to submit to the board a diploma or an official transcript indicating date of graduation and completion of required hours in each practice discipline for which the applicant is requesting licensure.

c. If the applicant graduated from a school that is not licensed by the board, direct the school to provide an official transcript showing completion of a course of study that meets the requirements of rule 645—61.14(157).

d. If the applicant has graduated from an apprenticeship program, the applicant must direct the United States Department of Labor to submit a certificate of completion.

e. Foreign-trained applicants. If educated outside the United States, attach an original evaluation of the applicant’s education from World Education Services (WES) or any other accredited evaluation service. An applicant may obtain an application for evaluation by contacting WES online at www.wes.org or at (212)966-6311, or by writing to WES, P.O. Box 5087, Bowling Green Station, New York, New York 10274-5087.

f. Examination requirements. Pass a national examination as prescribed by the board for the particular practice discipline with a score of 75 percent or greater.

(1) The applicant shall submit the test registration fee directly to the test service PSI at www.psiexams.com. NIC examinations are administered according to guidelines set forth by the National-Interstate Council of State Boards of Cosmetology.
(2) If applying for licensure by endorsement, the applicant shall complete the requirements set forth in rule 645—60.7(157).

60.2(2) Requirements for an instructor’s license. An applicant for an instructor’s license shall:
   a. Submit a completed application for licensure and the appropriate fee to the board;
   b. Be licensed in the state of Iowa in the specific practice discipline to be taught or be licensed as a cosmetologist who possesses the skill and knowledge required to instruct in that practice discipline;
   c. Provide documentation of completion of 1,000 hours of instructor’s training or two years’ active practice in the field of cosmetology within six years prior to application;
   d. Submit proof of completion of an instructor methods training course consisting of at least 16 hours;
   e. Submit proof of 60 hours of practical experience, excluding school hours, in the area of electrolysis prior to application for an instructor of electrolysis license.
   f. Pass an instructor’s national examination, which, effective January 1, 2008, shall be the NIC instructor examination unless the applicant is applying for an instructor’s license by endorsement as outlined in rule 645—60.7(157).

60.2(3) Conditions. The following conditions apply for all cosmetology arts and sciences licenses.
   a. Incomplete applications that have been on file in the board office for more than two years shall be considered invalid and shall be destroyed.
   b. The licensure fee is nonrefundable.
   c. Licensees who were issued their initial licenses within six months prior to the license renewal beginning date shall not be required to renew their licenses until the renewal month two years later.
   d. A new license granted by the board of cosmetology arts and sciences to an individual who holds multiple active licenses with the board shall have the same license expiration date as the licensee’s existing license(s). If the licensee holds only one active license with the board, the license expiration date shall be in the current renewal period unless licensure is issued within six months of the end of the renewal cycle, in which case subrule 60.8(2) shall apply.

60.2(4) Licensure by work experience. An applicant who has relocated to Iowa from a state that did not require licensure to practice the profession may submit proof of work experience in lieu of educational and training requirements, if eligible, in accordance with rule 645—19.2(272C).

645—60.3(157) Criteria for licensure in specific practice disciplines.

60.3(1) A cosmetology license is not a requirement for an electrology, esthetics, nail technology or manicurist license.

60.3(2) Core life sciences curriculum hours shall be transferable in their entirety from one practice discipline to another practice discipline.

60.3(3) Theory hours earned in each practice discipline of cosmetology arts and sciences may be used in applying for a cosmetology license.

60.3(4) A cosmetologist licensed after July 1, 2005, is not eligible to be certified in chemical peels, microdermabrasion, laser or intense pulsed light (IPL) and shall not provide those services.

60.3(5) Pedicuring shall only be done by a cosmetologist or nail technologist.

60.3(6) Facial waxing shall only be done by a cosmetologist or esthetician.

60.3(7) An initial license to practice manicuring shall not be issued by the board after December 31, 2007. A manicurist license issued on or before December 31, 2007, may be renewed subject to licensure requirements identified by statute and administrative rule unless the license becomes inactive. A manicurist license that becomes inactive cannot be reactivated or renewed.

645—60.4(157) Practice-specific training requirements. The board shall approve a licensee to provide the appropriate services once a licensee has complied with training requirements and submitted a completed application, the required supporting evidence, and applicable fees as specified in these rules. The applicant shall receive a certification following board approval.

60.4(1) Microdermabrasion.
a. Microdermabrasion shall only be performed by a licensed, certified esthetician or a cosmetologist who was licensed prior to July 1, 2005, and is certified by the board.
b. To be eligible to perform microdermabrasion services, the licensee shall:
   (1) Complete 14 contact hours of education specific to the material or apparatus used for microdermabrasion. Before an additional material or apparatus is utilized in the licensee’s practice, the licensee shall provide official certification of training on the material or apparatus.
   (2) Obtain from the program a certification of training that contains the following information:
      1. Date, location, course title;
      2. Number of contact hours; and
      3. Specific identifying description of the microdermabrasion machine covered by the course.
   (3) Complete a board-approved certification application form and submit to the board office the completed form, a copy of the certification of training, and the required fee pursuant to 645—subrule 5.5(14). The fee is nonrefundable.

60.4(2) Chemical exfoliation.
   a. Chemical exfoliation shall only be performed by a cosmetologist who was licensed prior to July 1, 2005, and is certified by the board to perform those services. Additional certification is not required for licensed estheticians.
   b. Chemical exfoliation procedures are limited to the removal of surface epidermal cells of the skin by using only non-medical-strength cosmetic preparations consistent with labeled instructions and as specified by these rules. This procedure is not intended to elicit viable epidermal or dermal wounding, injury, or destruction.
   c. To be eligible to perform chemical peels, a cosmetologist who was licensed prior to July 1, 2005, shall:
      (1) Complete 21 hours of training specific to the process and products to be used for chemical peels. Before an additional process or product is utilized in the licensee’s practice, the licensee shall provide official certification of training on the new process or product.
      (2) Obtain from the program a certification of training that contains the following information:
         1. Date, location, course title;
         2. Number of contact hours; and
         3. Specific identifying description of the chemical peel process and products covered by the course.
      (3) Complete a board-approved certification application form and submit to the board office the completed form, a copy of the certification of training, and the required fee pursuant to 645—subrule 5.5(15). The fee is nonrefundable.

60.4(3) Laser services.
   a. A cosmetologist licensed after July 1, 2005, shall not use laser products.
   b. An electrologist shall only provide hair removal services when using a laser.
   c. Estheticians and cosmetologists shall use laser for cosmetic purposes only.
   d. Cosmetologists licensed prior to July 1, 2005, electrologists and estheticians must be certified to perform laser services.
   e. When a laser service is provided to a minor by a licensed cosmetologist, esthetician or electrologist who has been certified by the board, the licensee shall work under the general supervision of a physician. The parent or guardian shall sign a consent form prior to services being provided. Written permission shall remain in the client’s permanent record for a period of five years.
   f. To be eligible to perform laser services, a cosmetologist who was licensed on or before July 1, 2005, an electrologist, or an esthetician shall:
      (1) Complete 40 hours of training specific to each laser machine, model or device to be used for laser services. Before an additional machine, model or device is utilized in the licensee’s practice, the licensee shall submit official certification of training on the new machine, model or device.
      (2) Obtain from the program a certification of training that contains the following information:
         1. Date, location, course title;
         2. Number of contact hours;
3. Specific identifying description of the laser equipment; and
4. Evidence that the training program includes a safety training component which provides a thorough understanding of the procedures to be performed. The training program shall address fundamentals of nonbeam hazards, management and employee responsibilities relating to control measures, and regulatory requirements.

(3) Complete a board-approved certification application form and submit to the board office the completed form, a copy of the certification of training, and the required fee pursuant to 645—subrule 5.5(14). The fee is nonrefundable.

60.4(4) IPL hair removal treatments.
   a. A cosmetologist licensed after July 1, 2005, shall not use IPL devices.
   b. An IPL device shall only be used for hair removal.
   c. Cosmetologists licensed prior to July 1, 2005, electrologists and estheticians must be certified to perform IPL services.
   d. When IPL hair removal services are provided to a minor by a licensed cosmetologist, esthetician or electrologist who has been certified by the board, the licensee shall work under the general supervision of a physician. The parent or guardian shall sign a consent form prior to services being provided. Written permission shall remain in the client’s permanent record for a period of five years.
   e. To be eligible to perform IPL hair removal services, a cosmetologist who was licensed on or before July 1, 2005, an electrologist, or an esthetician shall:
      1. Complete 40 hours of training specific to each IPL machine, model or device to be used for IPL hair removal services. Before an additional machine, model or device is utilized in the licensee’s practice, the licensee shall submit official certification of training on the new machine, model or device.
      2. Obtain from the program a certification of training that contains the following information:
         1. Date, location, course title;
         2. Number of contact hours;
         3. Specific identifying description of the IPL hair removal equipment; and
         4. Evidence that the training program includes a safety training component which provides a thorough understanding of the procedures to be performed. The training program shall address fundamentals of nonbeam hazards, management and employee responsibilities relating to control measures, and regulatory requirements.
      3. Complete a board-approved certification application form and submit to the board office the completed form, a copy of the certification of training, and the required fee pursuant to 645—subrule 5.5(14). The fee is nonrefundable.

60.4(5) Health history and incident reporting.
   a. Prior to providing laser or IPL hair removal, microdermabrasion or chemical peel services, the cosmetologist, esthetician, and electrologist shall complete a client health history of conditions related to the application for services and include it with the client’s records. The history shall include but is not limited to items listed in paragraph 60.4(5)“b.”
   b. A licensed cosmetologist, esthetician, or electrologist who provides services related to the use of a certified laser product, IPL device, chemical peel, or microdermabrasion shall submit a report to the board within 30 days of any incident in which provision of such services resulted in physical injury requiring medical attention. Failure to comply with this requirement shall result in disciplinary action by the board. The report shall include the following:
      1. A description of procedures;
      2. A description of the physical condition of the client;
      3. A description of any adverse occurrence, including:
         1. Symptoms of any complications including, but not limited to, onset and type of symptoms;
         2. A description of the services provided that caused the adverse occurrence;
         3. A description of the procedure that was followed by the licensee;
      4. A description of the client’s condition on termination of any procedures undertaken;
      5. If a client is referred to a physician, a statement providing the physician’s name and office location, if known;
(6) A copy of the consent form.

60.4(6) Failure to report. Failure to comply with paragraph 60.4(5) “b” when the adverse occurrence is related to the use of any procedure or device noted in the attestation may result in the licensee’s loss of authorization to administer the procedure or device noted in the attestation or may result in other sanctions provided by law.

60.4(7) A licensee shall not provide any services that constitute the practice of medicine.

[ARC 5755C, IAB 7/14/21, effective 8/18/21]

645—60.5(157) Licensure restrictions relating to practice.

60.5(1) A certified laser product or an intense pulsed light device shall only be used on surface epidermal layers of the skin except for hair removal.

60.5(2) A laser hair removal product or an intense pulsed light device shall not be used on a minor unless the minor is accompanied by a parent or guardian and then shall be used only under general supervision of a physician.

60.5(3) Persons licensed under Iowa Code chapter 157 shall not administer any practice of removing skin by means of a razor-edged instrument.

60.5(4) Persons licensed under this chapter who provide hair removal, manicuring and nail technology services shall not administer any procedure in which human tissue is cut, shaped, vaporized, or otherwise structurally altered, except for the use of a cuticle nipper.

60.5(5) Board-certified licensees providing microdermabrasion, chemical peels, laser or IPL hair removal treatments in a salon or barbershop setting shall not include any practice, activity, or treatment that constitutes the practice of medicine, osteopathic medicine, chiropractic or acupunctura.

60.5(6) Cosmetologists licensed prior to July 1, 2005, and licensed estheticians shall only perform medical aesthetic services in a medical spa under the delegation and supervision of a medical director as set forth by the Iowa board of medicine in rule 653—13.8(148,272C). The Iowa board of cosmetology arts and sciences does not license medical aestheticians.

60.5(7) Persons licensed under this chapter who provide apprenticeship programs must hold an active license sufficient to provide on-the-job training, must operate in an actively licensed establishment, and must comply with relevant United States Department of Labor laws and regulations for the operation of an apprenticeship program.

[ARC 2599C, IAB 6/22/16, effective 8/15/16; ARC 6376C, IAB 6/29/22, effective 8/3/22]

645—60.6(157) Consent form requirements. A licensed esthetician, cosmetologist, or electrologist, prior to providing services relating to a certified laser product, intense pulsed light device, chemical peel, or microdermabrasion, shall obtain from a client a consent form that:

1. Specifies in general terms the nature and purpose of the procedure(s);
2. Lists known risks associated with the procedure(s) if reasonably determinable;
3. States an acknowledgment that disclosure of information has been made and that questions asked about the procedure(s) have been satisfactorily answered;
4. Includes a signature of either the client for whom the procedure is performed or, if that client for any reason lacks legal capacity to consent, includes the signature of a person who has legal authority to consent on behalf of that client in those circumstances.

645—60.7(157) Licensure by endorsement. The board may issue a license by endorsement to any applicant from the District of Columbia or another state, territory, province or foreign country who has held an active license under the laws of another jurisdiction for at least 12 months during the past 24 months.

60.7(1) Applicants shall submit to the board a completed application and pay the licensure fee specified in 645—subrule 5.5(1).

60.7(2) Applicants shall provide verification of license(s) in a cosmetology practice discipline from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction’s board office if the verification includes:
a. Licensee’s name;

b. Date of initial licensure;

c. Current licensure status; and

d. Any disciplinary action taken against the license.

60.7(3) Applicants who graduated from a cosmetology school prior to January 1, 2000, shall have passed the state written and practical examination required by the state in which the applicants were originally licensed.

60.7(4) Applicants who graduated from a cosmetology school after January 1, 2000, shall have passed a national theory examination.

60.7(5) Licensure by verification. A person who is licensed in another jurisdiction but who is unable to satisfy the requirements for licensure by endorsement may apply for licensure by verification, if eligible, in accordance with rule 645—19.1(272C).

[ARC 8515B, IAB 2/10/10, effective 3/17/10; ARC 5755C, IAB 7/14/21, effective 8/18/21]

645—60.8(157) License renewal.

60.8(1) Biennial license renewal period for a license to practice cosmetology arts and sciences.

a. The renewal period shall begin on April 1 of one year and end on March 31 two years later. All licensees shall renew on a biennial basis.

b. The board may send a renewal notice by regular mail to each licensee at the address on record prior to the expiration of the license.

c. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive the notice does not relieve the licensee of the responsibility for renewing the license.

d. A new or reactivated license granted by the board to a licensee who holds a current license in another practice discipline in cosmetology shall have the same license expiration date as the licensee’s other license(s). If the licensee does not have another active license with the board, the license expiration date shall be in the current renewal period unless the license is issued within six months of the end of the renewal cycle and subrule 60.8(2) applies.

60.8(2) An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

60.8(3) License renewal. A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—64.2(157). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

c. Licensees currently licensed in Iowa but practicing exclusively in another state or serving honorably as active duty military or the spouse of active duty military service personnel may comply with Iowa continuing education requirements for license renewal by meeting the continuing education requirements of the state where the licensee practices. Those licensees living and practicing exclusively in a state which has no continuing education requirement for renewal of a license shall not be required to meet Iowa’s continuing education requirement but shall pay all renewal fees when due.

60.8(4) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

60.8(5) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the renewal. The licensee shall be assessed a late fee as specified in 645—subrule 5.5(3). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

60.8(6) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice cosmetology arts and sciences in Iowa until the license is reactivated. A licensee who practices cosmetology arts and sciences in the state of Iowa with an inactive license may
be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

60.8(7) Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used.

[ARC 3558C; IAB 1/3/18, effective 2/7/18; ARC 5755C; IAB 7/14/21, effective 8/18/21]

645—60.9 to 60.16 Reserved.

645—60.17(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

60.17(1) Submit a reactivation application on a form provided by the board.

60.17(2) Pay the reactivation fee that is due as specified in rule 645—5.1(147,157).

60.17(3) Provide verification of current competence to practice cosmetology arts and sciences by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction’s board office if the verification includes:
   1. Licensee’s name;
   2. Date of initial licensure;
   3. Current licensure status; and
   4. Any disciplinary action taken against the license; and

(2) Verification of completion of 6 hours of continuing education that meet the continuing education standards defined in rule 645—64.3(157,272C) within two years of application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction’s board office if the verification includes:
   1. Licensee’s name;
   2. Date of initial licensure;
   3. Current licensure status; and
   4. Any disciplinary action taken against the license; and

(2) Verification of completion of 12 hours of continuing education that meet the continuing education standards defined in rule 645—64.3(157,272C) within two years of application for reactivation.

(3) Rescinded IAB 11/21/07, effective 1/1/08.

60.17(4) Licensees who are instructors of cosmetology arts and sciences shall obtain an additional 6 hours of continuing education in teaching methodology as prescribed in 645—Chapter 64.

[ARC 3558C; IAB 1/3/18, effective 2/7/18; ARC 5755C; IAB 7/14/21, effective 8/18/21]

645—60.18(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—60.17(17A,147,272C) prior to practicing cosmetology arts and sciences in this state.

These rules are intended to implement Iowa Code chapters 272C and 157.

[Filed prior to 7/1/52; amended 4/21/53, 5/15/53, 10/1/59, 4/19/71]
[Filed 8/5/77, Notice 6/1/77—published 8/24/77, effective 10/1/77]
IAC 6/29/22

Professional Licensure [645] Ch 60, p.9

[Filed 4/28/78, Notice 12/28/77—published 5/17/78, effective 6/21/78]
[Filed 10/19/79, Notice 8/22/79—published 11/14/79, effective 12/21/79]
[Filed 2/27/81, Notice 12/10/80—published 3/18/81, effective 4/22/81]
[Filed 11/15/82, Notice 9/1/82—published 12/8/82, effective 1/15/83]
[Filed 10/6/83, Notice 7/20/83—published 10/26/83, effective 11/30/83]
[Filed 4/15/85, Notice 2/27/85—published 5/8/85, effective 6/12/85]
[Filed 8/5/85, Notice 6/5/85—published 8/28/85, effective 10/2/85]
[Filed emergency 7/10/87—published 7/29/87, effective 7/10/87]
[Filed 9/29/89, Notice 8/23/89—published 10/18/89, effective 11/22/89]
[Filed 2/2/90, Notice 12/27/89—published 2/21/90, effective 3/28/90]
[Filed 9/27/91, Notice 6/12/91—published 10/16/91, effective 11/20/91]
[Filed 1/3/92, Notice 9/4/91—published 1/22/92, effective 2/26/92]
[Filed 12/4/92, Notice 8/5/92—published 12/23/92, effective 1/29/93]
[Filed 4/19/95, Notice 2/1/95—published 5/10/95, effective 6/14/95]
[Filed 11/2/95, Notice 9/13/95—published 11/22/95, effective 12/27/95]
[Filed 11/15/96, Notice 9/11/96—published 12/4/96, effective 1/8/97]
[Filed 2/6/98, Notice 11/19/97—published 2/25/98, effective 4/1/98]
[Filed 2/19/99, Notice 12/2/98—published 3/10/99, effective 4/14/99]
[Filed 2/1/01, Notice 11/29/00—published 2/21/01, effective 3/28/01]
[Filed 2/13/02, Notice 11/28/01—published 3/6/02, effective 4/10/02]
[Filed 8/14/02, Notice 5/29/02—published 9/4/02, effective 10/9/02]
[Filed 2/12/03, Notice 12/25/02—published 3/5/03, effective 4/9/03]
[Filed 8/14/03, Notice 5/28/03—published 9/3/03, effective 10/8/03]
[Filed 2/10/04, Notice 11/26/03—published 3/3/04, effective 4/7/04]
[Filed 2/3/05, Notice 11/24/04—published 3/2/05, effective 4/6/05]
[Filed 8/5/05, Notice 5/25/05—published 8/31/05, effective 10/5/05]
[Filed 11/4/05, Notice 9/14/05—published 11/23/05, effective 12/28/05]
[Filed 11/4/05, Notice 9/28/05—published 11/23/05, effective 12/28/05]
[Filed 2/1/06, Notice 12/7/05—published 3/1/06, effective 4/5/06]
[Filed without Notice 8/22/07—published 9/12/07, effective 1/1/08]
[Filed 10/24/07, Notice 9/12/07—published 11/21/07, effective 1/1/08]
[Filed 12/5/08, Notice 10/8/08—published 12/31/08, effective 2/4/09]
[Filed ARC 8515B (Notice ARC 8330B, IAB 12/2/09), IAB 2/10/10, effective 3/17/10]
[Filed ARC 2599C (Notice ARC 2467C, IAB 3/16/16), IAB 6/22/16, effective 8/15/16]
[Filed ARC 3558C (Notice ARC 3372C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]
[Filed ARC 5755C (Notice ARC 5455C, IAB 2/24/21), IAB 7/14/21, effective 8/18/21]
[Filed ARC 6376C (Notice ARC 6258C, IAB 3/23/22), IAB 6/29/22, effective 8/3/22]

0 Two or more ARC

1 Effective date of 2/26/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
CHAPTER 61
LICENSURE OF SALONS AND SCHOOLS
OF COSMETOLOGY ARTS AND SCIENCES
[Prior to 7/28/87, Health Department Chs 149, 150]
[Prior to 12/23/92, see 645—Chapter 60]

645—61.1(157) Definitions.

“Apprentice” means a person who is at least 16 years of age, who is employed in an apprenticeable occupation, who is a resident of the state of Iowa, and who is registered in Iowa by the Office of Apprenticeship of the United States Department of Labor.

“Apprenticeship instructor” means an instructor who delivers theory instruction in apprenticeship programs and who must meet the United States Department of Labor’s requirements for career and technical instructors. It is recommended that all apprenticeship instructors have training in teaching techniques and adult learning styles.

“Apprenticeship program” means a program registered by the Office of Apprenticeship of the United States Department of Labor, which includes terms and conditions for the qualification, recruitment, selection, employment, and training of apprentices, including the requirement for a written apprenticeship agreement between a student and an active licensee in an active licensed salon.

“Apprenticeship sponsor” means an entity operating an apprenticeship program or an entity in whose name an apprenticeship program is being operated that is registered with or approved by the Office of Apprenticeship of the United States Department of Labor.

“Clinic area” means the area of the school where the paying customers will receive services.

“Dispensary” means a separate area to be used for storing and dispensing of supplies and sanitizing of all implements.

“Inactive license” means a salon license or a school license that has not been renewed as required or the license of a salon or school that has failed to meet stated obligations for renewal within a stated time.

“Mentor” means a licensee providing guidance in a mentoring program.

“Mentoring” means a program allowing students to experience cosmetology arts and sciences in a licensed salon under the guidance of a mentor.

“On-the-job trainer” means the individual providing instruction and supervision of the apprenticeship program practical hours. This individual must be a licensee of the board in the discipline for which the individual is training, and the training must occur in a licensed establishment.

“Salon license” means a license issued to an Iowa establishment to provide cosmetology arts and sciences services to paying customers.

“School” means a school of cosmetology arts and sciences.

“School license” means a license issued to an establishment to instruct students in cosmetology arts and sciences.

[ARC 3558C, IAB 1/3/18, effective 2/7/18; ARC 6376C, IAB 6/29/22, effective 8/3/22]

645—61.2(157) Salon licensing. No person shall operate a salon unless the owner has obtained a license issued by the board. A separate enclosed area inside a salon that is operated as an independent business for the purpose of providing cosmetology services shall be considered its own salon and shall not operate unless a salon license is obtained. To determine what defines an independent contractor versus an employee, persons should contact the Iowa division of labor services.

61.2(1) The owner shall complete a board-approved application form. Application forms may be obtained from the board’s website (www.idph.iowa.gov/licensure), or directly from the board office. All applications shall be submitted to the Board of Cosmetology Arts and Sciences, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

a. The application shall be completed according to the instructions contained in the application and submitted 30 days prior to the anticipated opening day. If the application is not completed according to the instructions, the application will not be reviewed by the board.

b. Each application shall be accompanied by the appropriate fees payable by check or money order to the Board of Cosmetology Arts and Sciences. The fees are nonrefundable.
61.2(2) Each salon shall meet the requirements for sanitary conditions established in 645—Chapter 63 to be eligible for licensing. The salon may be inspected for compliance with sanitation rules within 12 months following the issuance of the salon license.

61.2(3) Business may commence at the salon following activation of the license.

61.2(4) Incomplete applications that have been on file in the board office for more than two years shall be considered invalid and shall be destroyed. The records will be maintained after two years only if the applicant submits a written request to the board.

61.2(5) A salon license shall be issued for a specific location. A change in location or site of a salon shall require submission of an application for a new license and payment of the fee required by 645—subrule 5.5(11). A change of address without change of actual location shall not be construed as a new site.

61.2(6) A salon license is not transferable.
   a. A change in ownership of a salon shall require the issuance of a new license. “Change in ownership” means any change of controlling interest in any corporation or any change of name of sole proprietorship or partnership.
   b. A salon cannot be sold if disciplinary actions are pending.
   c. If a salon owner sells the salon, that owner must send the license certificate and a report of the sale to the board within 10 days of the date on which the sale is final. The owner of the salon on record shall retain responsibility for the salon until the notice of sale is received in the board office.
   d. The board may request legal proof of the ownership transfer.
   e. The owner shall notify the board in writing of a change of name or address within 30 days after the occurrence and, in addition, shall return the current certificate and pay the reissued certificate fee as specified in rule 645—5.5(147,157).

[ARC 8515B, IAB 2/10/10, effective 3/17/10; ARC 3558C, IAB 1/3/18, effective 2/7/18; ARC 5755C, IAB 7/14/21, effective 8/18/21]

645—61.3(157) Salon license renewal.

61.3(1) The biennial license renewal period for a salon license shall begin on January 1 of every odd-numbered year and end on December 31 two years later.

61.3(2) A renewal of license notice shall be electronically mailed to the owner of the salon prior to the expiration of the license. Failure to receive the renewal notice shall not relieve the owner of the obligation to pay the biennial renewal fee on or before the renewal date.

61.3(3) A salon that is issued a license within six months of the license renewal date will not be required to renew the license until the next renewal two years later.

61.3(4) The salon owner shall submit the completed application with the renewal fee to the board office before the license expiration date.

61.3(5) A salon shall be in full compliance with this chapter and 645—Chapter 63 to be eligible for renewal. When all requirements for license renewal are met, the salon shall be issued a license renewal.

61.3(6) If the renewal fee and renewal application are received in the office after the license expiration date, but within 30 days following the expiration date, the late fee for failure to renew before expiration shall be charged.

[ARC 3558C, IAB 1/3/18, effective 2/7/18; ARC 5755C, IAB 7/14/21, effective 8/18/21]

645—61.4(272C) Inactive salon license.

61.4(1) A salon that has not renewed the salon license within the required time frame will have an inactive license and shall not provide cosmetology services until the license is reactivated.

61.4(2) To reactivate a salon license, the reactivation application and fee shall be submitted to the board office.

[ARC 5755C, IAB 7/14/21, effective 8/18/21]

645—61.5(157) Display requirements for salons.

61.5(1) Every salon shall have a sign visible outside the entrance designating the place of business.

61.5(2) The most current salon license proof of renewal shall be posted in the salon front entrance area to provide the public a full, unobstructed view of the license.
61.5(3) The most current license proof of renewal for each licensee working in the salon shall be posted in the salon front entrance area to provide the public a full, unobstructed view of the license.

61.5(4) If the licensee works in more than one salon, the current proof of renewal shall be posted in the primary place of practice, and the licensee shall be able to provide the renewal upon request.

61.5(5) Each licensee and apprentice shall have a valid U.S. government-issued photo ID to provide to an agent of the board upon request as proof of identity.

[ARC 8515B, IAB 2/10/10, effective 3/17/10; ARC 2600C, IAB 6/22/16, effective 8/15/16; ARC 5755C, IAB 7/14/21, effective 8/18/21; ARC 6376C, IAB 6/29/22, effective 8/3/22]

645—61.6(147) Duplicate certificate for salons.

61.6(1) A duplicate certificate shall be required if the current certificate is lost, stolen or destroyed. A duplicate certificate shall only be issued under such circumstances.

61.6(2) A duplicate salon certificate shall be issued upon receipt of a completed application and receipt of the fee as specified in 645—subrule 5.5(5).

61.6(3) If the board receives a completed application stating that the owner of the salon has not received the certificate within 60 days after the certificate is mailed by the board, no fee shall be required for issuing the duplicate certificate.

[ARC 5755C, IAB 7/14/21, effective 8/18/21]

645—61.7(157) Licensure for schools of cosmetology arts and sciences.

61.7(1) An application for a school license shall be submitted 90 days prior to the anticipated opening day of the school to the Board of Cosmetology Arts and Sciences, Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075. Prior to board review, the application shall include:

a. A complete plan of the physical facilities and an explanation detailing how the facilities will be utilized relative to classrooms, clinic space, and a mentoring program;

b. A list of the names of licensed instructors including the school director(s) for the proposed school if the instructors and school director(s) have been hired by the school at the time of application;

c. Copies of the catalog, brochure, enrollment contract, student policies, and cancellation and refund policies that will be used by the school or distributed by the school to students and the public; and

d. The school’s course of study and curriculum, which shall meet the course of study requirements outlined in rule 645—61.14(157).

61.7(2) Prior to issuance of the school license, the school shall:

a. Submit a final list of licensed instructors and director(s) hired for the school. The number of instructors must meet the requirement outlined in Iowa Code section 157.8, with the exception of instructors for the mentoring program; and

b. Meet the requirements of this chapter and 645—Chapter 63 and pass the board’s inspection of the facility.

61.7(3) The school owner shall be interviewed by the board during the review of the application.

61.7(4) After all criteria have been met, the school license shall be granted for the location(s) identified in the school’s application.

61.7(5) Instruction of students shall not begin until the school license is activated.

61.7(6) The school must provide proof of registration with the Iowa college student aid commission.

61.7(7) Incomplete applications that have been on file in the board office for more than two years shall be considered invalid and shall be destroyed. The records shall be maintained after two years only if the applicant submits a written request to the board.

61.7(8) Existing school license, new location. A change of location shall require submission of an application for a new school license and payment of the license fee 90 days in advance of the anticipated date of opening. A change of address without a change of actual location shall not be construed as a new site.

61.7(9) Existing school license, new name. The owner shall notify the board in writing of a change of name within 30 days after the occurrence. In addition, the owner shall return the current certificate and pay the reissued certificate fee as specified in rule 645—5.5(147,157).
61.7(10) Existing school license, change of ownership. A school license is not transferable. A change in ownership of a school shall require the issuance of a new license. “Change in ownership” means any change of controlling interest in any corporation or any change of name of sole proprietorship or partnership.
  
a. A school cannot be sold if disciplinary actions are pending.
  
b. The board may request legal proof of the ownership transfer.
  
c. If a school owner sells the school, that owner must send the license certificate and a report of the sale to the board within ten days of the date on which the sale is final. The owner of the school on record shall retain responsibility for the school until the new school owner has been issued an active school license.
  
d. The new school owner shall follow all requirements as outlined in rule 645—61.7(157).

This rule is intended to implement Iowa Code sections 147.80, 157.6 and 157.8.

[ARC 8515B, IAB 2/10/10, effective 3/17/10; ARC 3558C, IAB 1/3/18, effective 2/7/18]

645—61.8(157) School license renewal.

61.8(1) The annual license renewal period for a school license shall begin on July 1 and end on June 30 one year later.

61.8(2) A renewal of license application shall be mailed to the school at least 60 days prior to the expiration of the license. Failure to receive the renewal application shall not relieve the school of the obligation to pay the annual renewal fee on or before the renewal date.

  
a. The renewal application and renewal fee shall be submitted to the board office before the license expiration date.
  
b. Schools shall be in full compliance with this chapter and 645—Chapter 63 to be eligible for renewal. When all requirements for license renewal are met, the school shall be issued a license renewal.
  
c. Schools shall successfully complete the annual inspection pursuant to Iowa Code sections 157.6 and 157.8.

61.8(3) A school that is issued a license within six months of the license renewal date will not be required to renew the license until the next renewal one year later.

61.8(4) If the renewal fee and renewal application are received in the office after the license expiration date, but within 30 days following the expiration date, the late fee for failure to renew before expiration shall be charged.

[ARC 8515B, IAB 2/10/10, effective 3/17/10; ARC 3558C, IAB 1/3/18, effective 2/7/18; ARC 5755C, IAB 7/14/21, effective 8/18/21]

645—61.9(272C) Inactive school license.

61.9(1) If the renewal application and fee are not received in the office within 30 days after the license expiration date, the school license is inactive. To reactivate the school license, the reactivation application and fee shall be submitted to the board.

61.9(2) A school that has not renewed the school license within the required time frame will have an inactive license and shall not provide schooling or services until the license is reactivated.

[ARC 3558C, IAB 1/3/18, effective 2/7/18]

645—61.10(157) Display requirements for schools.

61.10(1) Every school shall have a sign visible outside the entrance designating the place of business.

61.10(2) A school license and the current proof of renewal shall be posted in the school’s front entrance area to provide the public a full unobstructed view of the license.

61.10(3) The current license proof of renewal for each instructor working at the school shall be posted in the school’s front entrance area to provide the public a full unobstructed view of the license.

[ARC 3558C, IAB 1/3/18, effective 2/7/18; ARC 5755C, IAB 7/14/21, effective 8/18/21]

645—61.11(147) Duplicate certificate or wallet card for schools. Rescinded IAB 12/31/08, effective 2/4/09.

645—61.12(157) Physical requirements for schools of cosmetology arts and sciences. The school shall meet the following physical requirements:
61.12(1) The school premises shall have a minimum floor space of 3,000 square feet.

61.12(2) Each school shall provide a minimum of 100 square feet per student. When the enrollment in a school exceeds 30 students, additional floor space of 30 square feet shall be required for each additional student enrolled in the school.

61.12(3) Each licensed school offering a full cosmetology arts and sciences curriculum shall provide the following:
   a. At least one clinic area where the paying public will receive services. The clinic area shall be confined to the premises occupied by the school.
   b. A theory classroom(s) separate from the clinic area.
   c. A library that is maintained for students and consists of textbooks, current trade publications and business management materials.
   d. A separate area that shall be used as a dispensary. The dispensary shall be equipped with a lavatory, shelves or drawers for storing chemicals, cleansing agents and items, sterilization equipment and any other sanitation items required by 645—Chapter 63. Clean items and dirty items in the dispensary must be kept separately as required by 645—Chapter 63.
   e. Two restrooms that are equipped with toilets, lavatories, soap and disposable paper towel dispensers.
   f. A laundry room that is separated from the clinic area by a full wall or partition. Students may not lounge, eat, practice or study in the laundry room.
   g. A separate room that is equipped for the practice of esthetics and electrology.
   h. An administrative office.

61.12(4) Each licensed school offering a single discipline cosmetology arts and sciences curriculum shall provide the same physical space as outlined in 61.12(3). Single discipline schools are exempt from 61.12(3) “g” if the board did not originally approve an electrology or esthetics course of study in the curriculum.

This rule is intended to implement Iowa Code sections 157.6 and 157.8.

[ARC 3558C, IAB 1/3/18, effective 2/7/18]

645—61.13(157) Minimum equipment requirements. Each school of cosmetology arts and sciences shall have the following minimum equipment:
   1. Workstations equipped with chair, workstation, closed drawer or container for sanitized articles, and mirror (maximum of two students per unit);
   2. Treatment room(s) when electrology or esthetics or both are offered;
   3. One set of textbooks for each student and instructor;
   4. Shampoo bowls located in the clinic area and readily accessible for students and clients if the school offers a curriculum course in cosmetology;
   5. Audiovisual equipment available for each classroom;
   6. Chair and table area for each student in the classroom; and
   7. Labeled bottles and containers showing intended use of the contents.

This rule is intended to implement Iowa Code sections 157.6 and 157.8.

[ARC 3558C, IAB 1/3/18, effective 2/7/18]

645—61.14(157) Course of study requirements. A school of cosmetology arts and sciences shall not be approved by the board of cosmetology arts and sciences unless it complies with the course of study requirements as provided below.

61.14(1) Requirements for hours.
COSMETOLOGY CURRICULUM
Core life sciences 150 hours
Cosmetology theory 615 hours
(Including business and management related to the practice of cosmetology.)
Total core life sciences and cosmetology theory is 765 hours.
Applied practical instruction 1335 hours
Total course of study 2100 hours
(70 semester credit hours)

ELECTROLOGY CURRICULUM
Core life sciences 150 hours
Electrology theory 50 hours
Applied practical instruction 225 hours
Total course of study 425 hours
(14 semester credit hours)

ESTHETICS CURRICULUM
Core life sciences 150 hours
Esthetics theory 115 hours
Applied practical instruction 335 hours
Total course of study 600 hours
(20 semester credit hours)

NAIL TECHNOLOGY CURRICULUM
Core life sciences 150 hours
Nail technology theory 50 hours
Applied practical instruction 125 hours
Total course of study 325 hours
(11 semester credit hours)

Proof of curriculum requirements may be submitted to the board by either the clock hour or semester credit hour standard. Semester credit hours or the equivalent thereof shall be determined pursuant to administrative rules and regulations promulgated by the U.S. Department of Education.

61.14(2) Curriculum requirements.
   a. Theory instruction shall be taught from a standard approved textbook but may be supplemented by other related textbooks. Online coursework is allowed for theory instruction.
   b. Course subjects taught in the school curriculum, including skills and business management, shall relate to the specific practice discipline.
   c. Required hours for theory and applied practical hours do not have to be obtained from one school.
   d. Core life sciences curriculum hours shall be transferable in their entirety from one practice discipline to another practice discipline. Online coursework is allowed for core life sciences instruction.
   e. Only hours from accredited or board-approved school programs will be accepted.

61.14(3) Core life sciences curriculum. The core life sciences curriculum shall contain the following instruction:
   a. Human anatomy and physiology:
      Cell, metabolism and body systems,
      Human anatomy;
   b. Bacteriology;
   c. Infection control practices:
      Universal precautions,
      Sanitation,
      Sterilization,
Disinfection;

\( d \). Basic chemistry;

\( e \). Matter;

\( f \). Elements:

- Compounds and mixtures;
- Basic electricity;

\( g \). Electrical measurements:

- Reproduction of light rays,
- Infrared rays,
- Ultraviolet rays,
- Visible rays/spectrum;

\( i \). Safety;

\( j \). Hygiene and grooming:

- Personal and professional health;

\( k \). Professional ethics;

\( l \). Public relations; and

\( m \). State and federal law, administrative rules and standards.

Clock hours may be converted to credit hours using a standard, recognized method of conversion.

**61.14(4)** The school shall maintain a copy of the curriculum plan for two years after the curriculum plan was taught by the school.

[ARC 3558C, IAB 1/3/18, effective 2/7/18]

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**645—61.15(157) Instructors.** All instructors in a school of cosmetology arts and sciences shall be licensed by the department.

**61.15(1)** An instructor teaching a course in electrology, esthetics or nail technology shall also hold a license in that practice or hold a cosmetology license that shows proof of having completed training in those practices equivalent to that of a license holder in that practice.

**61.15(2)** An instructor teaching a course in microdermabrasion, chemical peels, intense pulsed lights (IPLs) and lasers shall be certified by the state of Iowa to provide each of the services, as set forth in rule 645—60.4(157).

**61.15(3)** A minimum of two instructors shall be employed on a full-time basis for up to 30 students and an additional instructor for each additional 15 students.

\( a \). The number of instructors for each school of cosmetology arts and sciences shall be based upon total enrollment.

\( b \). A student instructor shall not be used to meet licensed instructor-to-student ratios.

\( c \). A school with less than 30 students enrolled may have one licensed instructor on site in the school if offering only clinic services or only theory instruction in a single classroom and less than 15 students are present.

\( d \). If a school is offering clinic services and theory instruction simultaneously to less than 15 students, at least two licensed instructors must be on site.

\( e \). Area community colleges operating a school prior to September 1, 1982, with only one instructor per 15 students are not subject to this subrule and may continue to operate with the ratio of one instructor to 15 students. A student instructor shall not be used to meet licensed instructor-to-student ratios.

**61.15(4)** An instructor shall:

\( a \). Be responsible for and in direct charge of all physical and virtual core and theory classrooms and practical classrooms and clinics at all times;

\( b \). Familiarize students with the different standard supplies and equipment used in salons; and

\( c \). Not perform cosmetology services, with or without compensation, on the school premises except for demonstration purposes.

This rule is intended to implement Iowa Code chapter 157.

[ARC 8515B, IAB 2/10/10, effective 3/17/10 (See Delay note at the end of chapter); ARC 3558C, IAB 1/3/18, effective 2/7/18]
645—61.16(157) Student instructors. A student instructor shall be a graduate of an approved school of cosmetology arts and sciences. Each student instructor shall be under the direct supervision of a licensed instructor at all times.

645—61.17(157) Students.

61.17(1) A school of cosmetology arts and sciences shall, prior to the time a student is obligated for payment, inform the student of all provisions set forth in Iowa Code section 714.25. The school shall retain a copy of the signed statement for two years following the student’s graduating or leaving the program.

61.17(2) Students shall:
   a. Wear clean and neat uniforms at all times during school hours and during the mentoring program;
   b. Be supervised by a licensed instructor at all times except in a mentoring program when the students shall be under the guidance of a mentor;
   c. Be provided regularly scheduled breaks and a minimum of 30 minutes for lunch;
   d. Attend school no more than eight hours a day. Schools may offer additional hours to students who submit a written request for additional hours;
   e. Receive no compensation from the school for services performed on clients;
   f. Provide services to the public only after completion of a minimum of 10 percent of the course of study;
   g. Not be called from theory class to provide services to the public;
   h. Not be required to perform janitorial services or be allowed to volunteer for such services. Sanitation of the bathroom area shall be limited to replacing products and disinfecting the vanity and mirror surfaces. Sanitation of the toilet and bathroom floor areas is not to be performed by the student and is excluded from student sanitation duty; and
   i. Receive no credit or hours for decorating for marketing or merchandising events or for participating in demonstrations of cosmetology arts and sciences when the sole purpose of the event is to recruit students and the event is outside the curriculum course.

645—61.18(157) Attendance requirements.

61.18(1) A school of cosmetology arts and sciences shall have a written, published attendance policy.

61.18(2) Schools shall ensure:
   a. Students complete the hours required for each course of study set forth in rule 645—61.14(157).
   b. Student attendance policies are applied uniformly and fairly for all physical and virtual classes.
   c. Appropriate credit is given for all hours earned.
   d. All retake tests and projects to be redone are completed without benefit of additional hours earned. Time scheduled for such work will be scheduled at the school’s discretion.
   e. Hours or credit is not added to the accumulative student record as an award or deducted from the accumulative student record as a penalty.
   f. Work that must be done for missed hours must be allowed. The student must be given full credit for hours earned.

61.18(3) Pursuant to the federal Department of Education and accrediting standards agency, the school may adopt an absence policy not to exceed 10 percent of required coursework for doctor’s excuses and life events. In no way shall this policy create a penalty for the student nor excuse the student from the remaining 10 percent of required coursework.

This rule is intended to implement Iowa Code chapter 157.

[ARC 8515B, IAB 2/10/10, effective 3/17/10; ARC 3558C, IAB 1/3/18, effective 2/7/18]


61.19(1) A school may adopt an accelerated learning policy which includes the acceptance of life experience, prior knowledge learned and test-out procedures.
61.19(2) If the school has an accelerated learning policy, the policy shall be a written, published policy that clearly outlines the criteria for acceptance and hours or credit granted or for test-out procedures. The hours or credit granted for accelerated learning shall not exceed 15 percent of the student’s entire course of study and shall be documented in the participating student’s file.

a. After completion of all entrance requirements, a student may elect to sit for one or more academic written tests to evaluate the knowledge about subject matter gained from life experience or prior learning experience.

b. A student in a cosmetology arts and sciences course of study may be allowed to test out of a subject by sitting for final examinations covering the basic knowledge gained by a student who attends class sessions, or the school may accept and grant hours for prior or concurrent education and life experience.

c. A student who wishes to receive test-out credit or be granted hours for prior or concurrent education or life experience shall have maintained the academic grades and attendance policy standards set by the school.

d. The school may limit the number of times a student is allowed to sit for a test-out examination of a subject.

645—61.20(157) Mentoring program. Each cosmetology school must have a contract between the student, the school and the salon mentor that includes scheduling, liability insurance and purpose of the mentoring program.

61.20(1) Students shall not begin the mentoring program until they have completed a minimum of 50 percent of the total contact or credit hours and other requirements of the mentoring program established by the school.

61.20(2) Students may participate in a mentoring program for no more than 5 percent of the total contact or credit hours.

61.20(3) Students shall be under supervision of the mentor at all times. Students may perform the following: drape, shampoo, remove color and perm chemicals, remove perm rods, remove rollers, apply temporary rinses, apply reconditioners and rebuilders with the recommendation of the mentor, remove nail polish, file nails, perform hand and arm massage, remove cosmetic preparations, act as receptionist, handle retail sales, sanitize salon, consult with client (chairside manners), perform inventory, order supplies, prepare payroll and pay monthly bills, and hand equipment to the stylist.

61.20(4) The salon mentor’s responsibilities include the following: introduce the student to the salon and the client, record the time of the student’s attendance in salon, prepare evaluation, discuss performance, and allow the student to shadow.

61.20(5) A salon or school shall not compensate students when the students are participating in the mentoring program.

645—61.21(157) Graduate of a school of cosmetology arts and sciences.

61.21(1) A student shall be considered a graduate when the student has completed the required course of study and met the minimum attendance standard.

61.21(2) Students shall be given a final examination upon completion of the course of study but before graduation.

61.21(3) After passage of the final examination and completion of the entire course of study including all project sheets, students shall be issued a certificate of completion of hours required for the course of study.

645—61.22(157) Records requirements.

61.22(1) Each school of cosmetology arts and sciences shall maintain a complete set of student records. Individual student hours shall be kept on file at the school for two years following graduation.

61.22(2) Each school shall maintain daily teaching logs for all instructors, which shall be kept on file at the school for two years.
61.22(3) Prior to closure, the controlling school shall establish agreements with another school to maintain student and graduate transcripts and records. Prior to closure, the controlling school shall also notify the board in writing of the location of student records as established by the maintenance agreements and shall submit a copy of the maintenance agreements to the board. Provisions in the agreement must include maintenance of student transcript records for a period of no less than two years.

[ARC 8515B, IAB 2/10/10, effective 3/17/10]

645—61.23(157) Classrooms used for other educational purposes.

61.23(1) The licensed school of cosmetology arts and sciences shall not be used during scheduled instruction time or work experience time for any use other than for student instruction.

61.23(2) Persons attending other educational classes may not (en masse) pass through a classroom or clinic area while it is in use.

61.23(3) Noise level must not be disruptive to other classes.

61.23(4) Use of classrooms shall not usurp the space available for cosmetology instruction.

645—61.24(157) Public notice.

61.24(1) Advertisements shall indicate that all services are performed by students under the supervision of instructors.

61.24(2) A sign shall be clearly displayed in the entrance of the school that indicates in prominent lettering that students perform all services under the supervision of instructors.

61.24(3) A sign shall be clearly displayed in the entrance of a licensed establishment operating an apprenticeship program that indicates in prominent lettering that apprentices are employed at the establishment and may perform services under the supervision of a licensed apprenticeship supervisor.

[ARC 6376C, IAB 6/29/22, effective 8/3/22]

These rules are intended to implement Iowa Code chapters 272C and 157.

[Filed prior to 7/1/52; amended 4/21/53, 5/15/53, 10/1/59, 4/19/71]
[Filed 8/5/77, Notice 6/1/77—published 8/24/77, effective 10/1/77]
[Filed 4/28/78, Notice 12/28/77—published 5/17/78, effective 6/21/78]
[Filed 2/12/82, Notice 12/23/81—published 3/3/82, effective 4/9/82]
[Filed 10/6/83, Notice 7/20/83—published 10/26/83, effective 11/30/83]
[Filed 1/23/84, Notice 12/7/83—published 2/15/84, effective 5/2/84]
[Filed 11/15/84, Notice 9/26/84—published 12/5/84, effective 1/9/85]
[Filed emergency 7/10/87—published 7/29/87, effective 7/10/87]
[Filed 12/4/92, Notice 8/5/92—published 12/23/92, effective 1/29/93]
[Filed 11/2/95, Notice 9/13/95—published 11/22/95, effective 12/27/95]
[Filed 11/15/96, Notice 9/11/96—published 12/4/96, effective 1/8/97]
[Filed 2/6/98, Notice 11/19/97—published 2/25/98, effective 4/1/98]
[Filed 11/24/99, Notice 8/11/99—published 12/15/99, effective 1/19/00]
[Filed 2/13/02, Notice 11/28/01—published 3/6/02, effective 4/10/02]
[Filed 2/12/03, Notice 12/25/02—published 3/5/03, effective 4/9/03]
[Filed 8/14/03, Notice 5/28/03—published 9/3/03, effective 10/8/03]
[Filed 2/3/05, Notice 11/24/04—published 3/2/05, effective 4/6/05]
[Filed 4/10/05, Notice 9/28/05—published 11/23/05, effective 12/28/05]
[Filed 2/1/06, Notice 12/7/05—published 3/1/06, effective 4/5/06]
[Filed 10/24/07, Notice 9/12/07—published 11/21/07, effective 1/1/08]
[Filed 12/5/08, Notice 10/8/08—published 12/31/08, effective 2/4/09]
[Filed ARC 8515B (Notice ARC 8330B, IAB 12/2/09), IAB 2/10/10, effective 3/17/10]
[Editorial change: IAC Supplement 3/24/10]
[Filed ARC 2600C (Notice ARC 2465C, IAB 3/16/16), IAB 6/22/16, effective 8/15/16]
[Filed ARC 3558C (Notice ARC 3372C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]
[Filed ARC 5755C (Notice ARC 5455C, IAB 2/24/21), IAB 7/14/21, effective 8/18/21]
March 17, 2010, effective date of 61.15(3) delayed 70 days by the Administrative Rules Review Committee at its meeting held March 8, 2010.
OPTOMETRISTS

CHAPTER 180  LICENSURE OF OPTOMETRISTS
CHAPTER 181  CONTINUING EDUCATION FOR OPTOMETRISTS
CHAPTER 182  PRACTICE OF OPTOMETRISTS
CHAPTER 183  DISCIPLINE FOR OPTOMETRISTS

CHAPTER 180
LICENSURE OF OPTOMETRISTS
[Prior to 6/13/01, see 645—Chapter 180]

645—180.1(154) Definitions. For purposes of these rules, the following definitions shall apply:

“Active license” means a license that is current and has not expired.

“Approved program or activity” means a continuing education program or activity meeting the standards set forth in these rules.

“Board” means the board of optometry.

“CELMO” means the Council on Endorsed Licensure Mobility for Optometrists.

“Grace period” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“Inactive license” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“Licensee” means any person licensed to practice as an optometrist in the state of Iowa.

“Licensure by endorsement” means the issuance of an Iowa license to practice optometry to an applicant who is or has been licensed in another state.

“Mandatory training” means training on identifying and reporting child abuse or dependent adult abuse required of optometrists who are mandatory reporters. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69. The full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

“NBEO” means the National Board of Examiners in Optometry.

“Optometrist” means an optometrist who is licensed to practice optometry in Iowa and who is certified by the board of optometry to employ all diagnostic and therapeutic pharmaceutical agents for the purpose of diagnosis and treatment of the conditions of the human eye and adnexa, excluding the use of injections other than to counteract an anaphylactic reaction, and notwithstanding Iowa Code section 147.107, may without charge supply any of the above pharmaceuticals to commence a course of therapy, with the exclusions cited in Iowa Code chapter 154.

“Reactivate” or “reactivation” means the process as outlined in rule 645—180.11(17A,147,272C) by which an inactive license is restored to active status.

“Reinstatement” means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

“TPA” means therapeutic pharmaceutical agents.

[ARC 0899C, IAB 8/7/13, effective 9/11/13]

645—180.2(154) Requirements for licensure.

180.2(1) The following criteria shall apply to licensure:

a. Applicants shall complete a board-approved application. Applications may be completed at the board’s website (www.idph.iowa.gov/licensure).

b. Applicants shall submit the appropriate fees payable to the Board of Optometry. The fees are nonrefundable.
c. No application will be considered complete until official copies of academic transcripts sent directly to the board from an accredited school or college of optometry are received by the board and the applicant submits proof of satisfactory completion of all educational requirements contained in Iowa Code chapter 154.

d. Applicants shall provide evidence of passing all current NBEO examinations including the Treatment and Management of Ocular Disease examination.

e. Licensees who were issued their licenses within six months prior to the renewal date shall not be required to renew their licenses until the renewal date two years later.

180.2(2) Rescinded IAB 8/7/13, effective 9/11/13.
[ARC 0899C, IAB 8/7/13, effective 9/11/13; ARC 3428C, IAB 10/25/17, effective 11/29/17; ARC 5776C, IAB 7/14/21, effective 8/18/21; ARC 6374C, IAB 6/29/22, effective 8/3/22]

645—180.3(154) Licensure by endorsement.

180.3(1) Applicants who have been licensed as an optometrist in another state may apply for licensure by endorsement by submitting the following:

a. A completed licensure application and payment of the application fee.

b. Verification of license(s) from every jurisdiction in which the applicant has been licensed showing the licensee’s name, date of initial licensure, current licensure status, and any disciplinary action taken against the license.

c. Evidence of a passing score for all parts of the NBEO examination at the time of licensure as an optometrist in another state and evidence of a passing score for the Treatment and Management of Ocular Disease examination.

d. Verification of current competence to practice as an optometrist by satisfying one of the following criteria:

(1) Current CELMO certification; or
(2) Practice as an optometrist for a minimum of 2,080 hours during the preceding two-year period; or
(3) Employment as a faculty member teaching optometry in an accredited school of optometry for at least one academic year during the preceding two-year period; or
(4) Completion of a minimum of 50 hours of continuing education during the preceding two-year period; or
(5) Passing the NBEO examination during the preceding two-year period.

180.3(2) Applicants for licensure by endorsement who were issued their Iowa licenses within six months prior to the renewal date shall not be required to renew their licenses until the renewal date two years later.

180.3(3) Licensure by verification. A person who is licensed in another jurisdiction but who is unable to satisfy the requirements for licensure by endorsement may apply for licensure by verification, if eligible, in accordance with rule 645—19.1(272C).
[ARC 0899C, IAB 8/7/13, effective 9/11/13; ARC 5776C, IAB 7/14/21, effective 8/18/21; ARC 6374C, IAB 6/29/22, effective 8/3/22]

645—180.4 Reserved.

645—180.5(154) License renewal.

180.5(1) The biennial license renewal period for a license to practice optometry shall begin on July 1 of an even-numbered year and end on June 30 two years later. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

180.5(2) An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

180.5(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—181.2(154) and the mandatory reporting requirements of subrule 180.5(4). A licensee whose license was reactivated during the current
renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

180.5(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee’s employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of training in child abuse identification and reporting as required by Iowa Code section 232.69(3) “b” in the previous three years or condition(s) for waiver of this requirement as identified in paragraph 180.5(4) “e.”

b. A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of training in dependent adult abuse identification and reporting as required by Iowa Code section 235B.16(5) “b” in the previous three years or condition(s) for waiver of this requirement as identified in paragraph 180.5(4) “e.”

c. The course(s) shall be the curriculum provided by the Iowa department of human services.

d. The licensee shall maintain written documentation for three years after mandatory training as identified in paragraphs 180.5(4) “a” to “c,” including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

1. Is engaged in active duty in the military service of this state or the United States.

2. Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including an exemption of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in rule 645—4.14(272C).

f. The board may select licensees for audit of compliance with the requirements in paragraphs 180.5(4) “a” to “e.”

180.5(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

180.5(6) A person licensed to practice optometry shall keep the license certificate and renewal displayed in a conspicuous public place at the primary site of practice.

180.5(7) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the renewal. The licensee shall be assessed a late fee as specified in 645—subrule 5.12(3). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

180.5(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as an optometrist in Iowa until the license is reactivated. A licensee who practices as an optometrist in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

645—180.6 to 180.10 Reserved.

645—180.11(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee must submit the following:

180.11(1) A completed reactivation application and payment of the application fee.
180.11(2) Verification of license(s) from every jurisdiction in which the licensee has been licensed showing the licensee’s name, date of initial licensure, current licensure status, and any disciplinary action taken against the license.

180.11(3) Verification of current competence to practice as an optometrist by satisfying one of the following criteria:
   a. Current CELMO certification; or
   b. Practice as an optometrist for a minimum of 2,080 hours during the preceding two-year period; or
   c. Employment as a faculty member teaching optometry in an accredited school of optometry for at least one academic year during the preceding two-year period; or
   d. Completion of a minimum of 50 hours of continuing education during the preceding two-year period; or
   e. Passing the NBEO examination during the preceding two-year period.

[ARC 6374C, IAB 6/29/22, effective 8/3/22]

645—180.12(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—180.11(17A,147,272C) prior to practicing as an optometrist in this state.

These rules are intended to implement Iowa Code chapters 17A, 147, 154 and 272C.

[Filed 5/25/01, Notice 4/4/01—published 6/13/01, effective 7/18/01]
[Filed 7/18/02, Notice 5/15/02—published 8/7/02, effective 9/11/02]
[Filed 1/15/03, Notice 11/13/02—published 2/5/03, effective 3/12/03]
[Filed 7/8/05, Notice 5/11/05—published 8/3/05, effective 9/7/05]
[Filed 1/13/06, Notice 10/26/05—published 2/1/06, effective 3/8/06]
[Filed 1/12/07, Notice 11/8/06—published 1/31/07, effective 3/7/07]
[Filed 10/14/08, Notice 8/27/08—published 11/5/08, effective 12/10/08]
[Filed ARC 9641B (Notice ARC 9519B, IAB 5/18/11), IAB 7/27/11, effective 8/31/11]
[Filed ARC 0899C (Notice ARC 0680C, IAB 4/3/13), IAB 8/7/13, effective 9/11/13]
[Filed ARC 3428C (Notice ARC 3223C, IAB 8/2/17), IAB 10/25/17, effective 11/29/17]
[Filed ARC 5071C (Notice ARC 4854C, IAB 1/15/20), IAB 7/1/20, effective 8/5/20]
[Filed ARC 5776C (Notice ARC 5458C, IAB 2/24/21), IAB 7/14/21, effective 8/18/21]
[Filed ARC 6374C (Notice ARC 6095C, IAB 12/15/21), IAB 6/29/22, effective 8/3/22]

0 Two or more ARCs
CHAPTER 25
CHILD SUPPORT NONCOMPLIANCE

657—25.1(252J) Definitions. For the purpose of this chapter the following definitions shall apply:

“Act” means Iowa Code chapter 252J.

“Board” means the Iowa board of pharmacy.

“Certificate” means a document known as a certificate of noncompliance which is provided by the child support unit certifying that the named licensee is not in compliance with a support order or with a written agreement for payment of support entered into by the child support unit and the licensee.

“Child support unit” means the child support recovery unit of the Iowa department of human services.

“Denial notice” means a board notification denying an application for the issuance or renewal of a license as required by the Act.

“License” means a license to practice pharmacy, a registration to practice as a pharmacist-intern, a registration to practice as a pharmacy technician, a registration to practice as a pharmacy support person, or a registration to possess, prescribe, dispense, administer, distribute, or otherwise handle controlled substances under Iowa Code chapter 124.

“Licensee” means an individual to whom a license has been issued or who is seeking the issuance of a license.

“Revocation or suspension notice” means a board notification suspending a license for an indefinite or specified period of time or a notification revoking a license as required by the Act.

“Withdrawal certificate” means a document known as a withdrawal of a certificate of noncompliance provided by the child support unit certifying that the certificate is withdrawn and that the board may proceed with issuance, reinstatement, or renewal of a license.

[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 3346C, IAB 9/27/17, effective 11/1/17; Editorial change: IAC Supplement 6/29/22]

657—25.2(252J) Issuance or renewal of license—denial. The board shall deny the issuance or renewal of a license upon the receipt of a certificate from the child support unit. This rule shall apply in addition to the procedures set forth in the Act.

25.2(1) Service of denial notice. Notice shall be served upon the licensee by certified mail, return receipt requested; by personal service; or through authorized counsel.

25.2(2) Effective date of denial. The effective date of the denial of issuance or renewal of a license, as specified in the notice, shall be 60 days following service of the notice upon the licensee.

25.2(3) Preparation and service of denial notice. The executive director of the board is authorized to prepare and serve the notice upon the licensee.

25.2(4) Licensee responsible to inform board. Licensees shall keep the board informed of all court actions and all child support unit actions taken under or in connection with the Act and shall provide the board with copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to the Act, all court orders entered in such actions, and any withdrawal certificates issued by the child support unit.

25.2(5) Reinstatement following license denial. All board fees required for application, license renewal, or license reinstatement shall be paid by licensees before a license will be issued, renewed, or reinstated after the board has denied the issuance or renewal of a license pursuant to the Act.

25.2(6) Effect of filing in district court. In the event a licensee files a timely district court action following service of a notice, the board shall continue with the intended action described in the notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the denial of the issuance or renewal of a license, the board 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.

25.2(7) Final notification. The board shall notify the licensee in writing through regular first-class mail, or such other means as the board determines appropriate in the circumstances, within ten days.
of the effective date of the denial of the issuance or renewal of a license and shall similarly notify the licensee if the license is issued or renewed following the board’s receipt of a withdrawal certificate.
[ARC 3346C, IAB 9/27/17, effective 11/1/17]

657—25.3(252J) Suspension or revocation of a license. The board shall suspend or revoke a license upon the receipt of a certificate from the child support unit according to the procedures set forth in the Act. This rule shall apply in addition to the procedures set forth in the Act.

25.3(1) Service of revocation or suspension notice. Revocation or suspension notice shall be served upon the licensee by certified mail, return receipt requested; by personal service; or through authorized counsel.

25.3(2) Effective date of revocation or suspension. The effective date of the suspension or revocation of a license, as specified in the revocation or suspension notice, shall be 60 days following service of the revocation or suspension notice upon the licensee.

25.3(3) Preparation and service of revocation or suspension notice. The executive director of the board is authorized to prepare and serve the revocation or suspension notice upon the licensee and is directed to notify the licensee that the license will be suspended unless the license is already suspended on other grounds. In the event that the license is on suspension, the executive director shall notify the licensee of the board’s intention to revoke the license.

25.3(4) Licensee responsible to inform board. The licensee shall keep the board informed of all court actions and all child support unit action taken under or in connection with the Act and shall provide the board with copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to the Act, all court orders entered in such actions, and any withdrawal certificates issued by the child support unit.

25.3(5) Reinstatement following license suspension, revocation, or denial of renewal. A licensee shall pay all board fees required for license renewal or license reinstatement, and all continuing education requirements shall be met, before a license will be reinstated after the board has suspended a license pursuant to the Act. A licensee whose license to practice pharmacy has been revoked shall complete the examination components as indicated in 657—subrule 2.4(1) and shall pay all required examination fees pursuant to 657—subrule 2.5(3). A licensee whose registration to practice as a pharmacist-intern, as a pharmacy technician, or as a pharmacy support person or whose registration to handle controlled substances under Iowa Code chapter 124 has been revoked shall complete the appropriate application and pay all board fees required for new registration.

25.3(6) Effect of filing in district court. In the event a licensee files a timely district court action pursuant to the Act and following service of a revocation or suspension notice, the board shall continue with the intended action described in the revocation or suspension notice upon the receipt of a court order lifting the stay, dismissing the action, or otherwise directing the board to proceed. For purposes of determining the effective date of the suspension or revocation, the board 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.

25.3(7) Final notification. The board shall notify the licensee in writing through regular first-class mail, or such other means as the board determines appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a license and shall similarly notify the licensee if a license is reinstated following the board’s receipt of a withdrawal certificate.
[ARC 8673B, IAB 4/7/10, effective 6/1/10; ARC 3346C, IAB 9/27/17, effective 11/1/17; ARC 4579C, IAB 7/31/19, effective 9/4/19]

657—25.4(17A,22,252J) Share information. Notwithstanding any statutory confidentiality provision, the board may share information with the child support unit through manual or automated means for the sole purpose of identifying applicants or licensees subject to enforcement under the Act.

These rules are intended to implement Iowa Code chapter 252J.
[Filed 5/1/96, Notice 1/3/96—published 5/22/96, effective 6/26/96]
[Filed 2/22/99, Notice 10/21/98—published 3/10/99, effective 4/14/99]
[Filed ARC 8673B (Notice ARC 8380B, IAB 12/16/09), IAB 4/7/10, effective 6/1/10]
[Filed ARC 3346C (Notice ARC 3133C, IAB 6/21/17), IAB 9/27/17, effective 11/1/17]
[Filed ARC 4579C (Notice ARC 4391C, IAB 4/10/19), IAB 7/31/19, effective 9/4/19]
[Editorial change: IAC Supplement 6/29/22]
CHAPTER 26
PETITIONS FOR RULE MAKING

657—26.1(17A) Petition for rule making. Any person, association, agency, or political subdivision may file a petition for rule making with the board of pharmacy at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. A petition is deemed filed when received by that office. The board shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the board an extra copy for this purpose. The petition must be typewritten, machine printed, or legibly handwritten in ink and must substantially conform to the following form:

IOWA BOARD OF PHARMACY

<table>
<thead>
<tr>
<th>Petition by (Name of Petitioner)</th>
<th>for the (adoption, amendment, or repeal) of rules relating to (state subject matter).</th>
</tr>
</thead>
</table>

The petition shall include the following information:
1. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.
2. A citation to any law deemed relevant to the board’s authority to take the action urged or to the desirability of that action.
3. A brief summary of petitioner’s arguments in support of the action urged in the petition.
4. A brief summary of any data supporting the action urged in the petition.
5. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the proposed action which is the subject of the petition.
6. Any request by petitioner for a meeting provided for by rule 657—26.4(17A).
7. Original signature of petitioner and date signed.

[ARC 3346C, IAB 9/27/17, effective 11/1/17; Editorial change: IAC Supplement 6/29/22]

657—26.2(17A) Briefs. The petitioner may attach a brief to the petition in support of the action urged in the petition. The board may request a brief from the petitioner or from any other person concerning the substance of the petition.

657—26.3(17A) Inquiries. Inquiries concerning the status of a petition for rule making may be made to Executive Director, Iowa Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688, or via electronic mail to andrew.funk@iowa.gov.

[ARC 3346C, IAB 9/27/17, effective 11/1/17]

657—26.4(17A) Board consideration.

26.4(1) Initial activities. Within 14 days after the filing of a petition, the board shall submit a copy of the petition and any accompanying brief to the administrative rules coordinator and to the administrative rules review committee (ARRC). Upon request by the petitioner, the board shall schedule a brief and informal meeting between the petitioner and the board, a member of the board, or a member of board staff to discuss the petition. The board may request that the petitioner submit additional information or argument concerning the petition. The board may also solicit comments from any person on the substance of the petition. Any person may submit to the board comments on the substance of the petition.

26.4(2) Decision issued. Within 60 days after the filing of the petition, or within any longer period agreed to by the petitioner, the board shall, in writing, deny the petition, and notify the petitioner and the ARRC of its action and the specific grounds for the denial, or grant the petition and notify the petitioner and the ARRC that it has initiated rule-making proceedings on the subject of the petition. The petitioner
and the ARRC shall be deemed notified of the denial or grant of the petition on the date when the board mails or delivers the required notification to the petitioner and the ARRC.

26.4(3) Denial for nonconformity. Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the board’s rejection of the original petition.

These rules are intended to implement Iowa Code section 17A.7.

[ARC 5348C; IAB 12/30/20, effective 2/3/21]
CHAPTER 27
DECLARATORY ORDERS

657—27.1(17A) Petition for declaratory order. Any person may file a petition with the board of pharmacy, hereinafter referred to as “the board,” for a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the Iowa Board of Pharmacy at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. A petition is deemed filed when it is received by that office. The board shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the board an extra copy for this purpose. The petition shall be typewritten or legibly handwritten in ink and shall substantially conform to the following form:

IOWA BOARD OF PHARMACY

Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved).

PETITION FOR DECLARATORY ORDER

The petition shall provide the following information:

1. A clear and concise statement of all relevant facts on which the order is requested.
2. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law.
3. The questions petitioner wants answered, stated clearly and concisely.
4. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
5. The reasons for requesting the declaratory order and disclosure of the petitioner’s interest in the outcome.
6. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner’s knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
7. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition.
8. Any request by petitioner for a meeting provided for by 657—27.7(17A).
9. A statement indicating the person to whom communications concerning the petition should be directed.
10. The name, mailing address, and telephone number of the petitioner and petitioner’s representative.
11. The original signature of the petitioner or the petitioner’s representative and the date signed.

[ARC 3346C; IAB 9/27/17, effective 11/1/17; Editorial change: IAC Supplement 6/29/22]

657—27.2(17A) Notice of petition. Within 15 days after receipt of a petition for a declaratory order, the board shall give notice of the petition to all persons not served by the petitioner pursuant to 657—27.6(17A) to whom notice is required by any provision of law. The board may also give notice to any other persons.

657—27.3(17A) Intervention.

27.3(1) Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 20 days of the filing of a petition for declaratory order shall be allowed to intervene in a proceeding for a declaratory order.

27.3(2) Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the board.

27.3(3) A petition for intervention shall be filed at the board office at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. Such a petition is deemed filed when it is received by that office.
The board will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention shall be typewritten or legibly handwritten in ink and shall substantially conform to the following form:

**IOWA BOARD OF PHARMACY**

```plaintext
Petition by (Name of Original Petitioner) for a Declaratory Order on (Cite provisions of law cited in original petition).}

{PETITION FOR INTERVENTION
```

The petition for intervention shall provide the following information:

1. Facts supporting the intervenor’s standing and qualifications for intervention.
2. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.
3. Reasons for requesting intervention and disclosure of the intervenor’s interest in the outcome.
4. A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor’s knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
5. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented.
6. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.
7. A statement indicating the person to whom communications concerning the petition should be directed.
8. The name, mailing address, and telephone number of the intervenor and intervenor’s representative.
9. The original signature of the intervenor or the intervenor’s representative and the date signed.

[ARC 3346C; IAB 9/27/17; effective 11/1/17; Editorial change: IAC Supplement 6/29/22]

**657—27.4(17A) Briefs.** The petitioner or any intervenor may file a brief in support of the position urged. The board may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

**657—27.5(17A) Inquiries.** Inquiries concerning the status of a declaratory order proceeding may be made to the Iowa Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688.

[ARC 3346C; IAB 9/27/17, effective 11/1/17]

**657—27.6(17A) Service and filing of petitions and other papers.**

27.6(1) *When service required.* Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

27.6(2) *Filing—when required.* All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the Iowa Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the board.

27.6(3) *Method of service, time of filing, and proof of mailing.* Method of service, time of filing, and proof of mailing shall be as provided by 657—35.17(17A,272C).

[ARC 3346C; IAB 9/27/17, effective 11/1/17]
657—27.7(17A) Consideration. Upon request by petitioner, the board shall schedule a brief and informal meeting between the original petitioner, all intervenors, and the board, a member of the board, or a member of the staff of the board, to discuss the questions raised. The board may solicit comments from any person on the questions raised. Also, comments on the questions raised may be submitted to the board by any person.

657—27.8(17A) Action on petition.

27.8(1) Within the time allowed by Iowa Code section 17A.9(5), after receipt of a petition for a declaratory order, the board shall take action on the petition as required by Iowa Code section 17A.9(5).

27.8(2) The date of issuance of an order or of a refusal to issue an order is as defined in 657—35.2(17A,272C).

[ARC 3346C, IAB 9/27/17, effective 11/1/17]

657—27.9(17A) Refusal to issue order.

27.9(1) The board shall not issue a declaratory order where prohibited by Iowa Code section 17A.9(1) and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

1. The petition does not substantially comply with the required form.
2. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the board to issue an order.
3. The board does not have jurisdiction over the questions presented in the petition.
4. The questions presented by the petition are also presented in a current rule making, contested case, or other board or judicial proceeding, that may definitively resolve them.
5. The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.
6. The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.
7. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.
8. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge a board decision already made.
9. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner.
10. The petitioner requests the board to determine whether a statute is unconstitutional on its face.

27.9(2) A refusal to issue a declaratory order shall indicate the specific grounds for the refusal and constitutes final board action on the petition.

27.9(3) Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the refusal to issue an order.

[ARC 3346C, IAB 9/27/17, effective 11/1/17]

657—27.10(17A) Contents of declaratory order—effective date. In addition to the order itself, a declaratory order shall contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion. A declaratory order is effective on the date of issuance.

657—27.11(17A) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

657—27.12(17A) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the board, the petitioner, and
any intervenors and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the board. The issuance of a declaratory order constitutes final board action on the petition.

These rules are intended to implement Iowa Code section 17A.9.

[Filed 1/21/92, Notice 10/16/91—published 2/19/92, effective 3/25/92]
[Filed ARC 3346C (Notice ARC 3133C, IAB 6/21/17), IAB 9/27/17, effective 11/1/17]
[Editorial change: IAC Supplement 6/29/22]
CHAPTER 28
AGENCY PROCEDURE FOR RULE MAKING

657—28.1(17A) Applicability. Except to the extent otherwise expressly provided by statute, all rules adopted by the board of pharmacy, hereinafter referred to as “board,” are subject to the provisions of Iowa Code chapter 17A, the Iowa administrative procedure Act, and the provisions of this chapter.

[ARC 3641C, IAB 2/14/18, effective 3/21/18]

657—28.2(17A) Definitions.

“Administrative rules review committee” or “ARRC” means a bipartisan standing committee composed of five senators and five representatives that meets on a regular basis for the purpose of selectively reviewing rules whether proposed or in effect.

“ARC” means the governor’s administrative rules coordinator.

“ARC number” means the identification number assigned by the ARC to each rule making document.

“Iowa Administrative Bulletin” or “IAB” is the official bimonthly publication that contains the text or texts of notices of intended action and of adopted rules.

“Notice of Intended Action” means a published notice of the board’s intent to adopt, amend, or rescind one or more rules pursuant to Iowa Code section 17A.4(1).

[ARC 3641C, IAB 2/14/18, effective 3/21/18]

657—28.3(17A) Solicitation of comments before notice. In addition to seeking information by other methods, the board may, before publication of a Notice of Intended Action, solicit comments from the public on a subject matter of possible rule making by causing notice to be published in the Iowa Administrative Bulletin of the subject matter and indicating where, when, and how persons may comment.

[ARC 3641C, IAB 2/14/18, effective 3/21/18]

657—28.4(17A) Public rule-making docket. Proposed rule making is made available for inspection and comment by the public through the websites identified in this rule.

28.4(1) Proposed rule making. Each proposed rule making is published in the Iowa Administrative Bulletin and can be found on the state’s administrative rules website at rules.iowa.gov. Each proposed rule making is identified by agency and by ARC number and shall include information on the opportunity to directly submit public comments, suggestions, and objections regarding the proposed rule making, including the deadline for submission of such comments.


28.4(3) Board notification of proposed rule making. Persons desiring to receive copies of future Notices of Intended Action may subscribe on the board’s website at pharmacy.iowa.gov.

28.4(4) Public participation—written comments. For at least 20 days after publication of the Notice of Intended Action, persons may submit written comments on the proposed rule. Such written submissions shall identify the proposed rule to which they relate and shall be submitted to the Iowa Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688; or to the person designated in the Notice of Intended Action.

28.4(5) Public participation—public hearings. The board may, at any time, schedule a public hearing in accordance with rule 657—28.5(17A) on a proposed rule. The board shall schedule a public hearing on a proposed rule if, within 20 days after the published Notice of Intended Action, a written request for an opportunity to make oral presentations is submitted to the board by the ARRC, a governmental subdivision, an agency, an association having not less than 25 members, or at least 25 persons. The request shall contain the following information:

a. A request by one or more individual persons shall include the printed name, signature, address, telephone number, and email address of each person.
b. A request by an association shall contain a statement that the association has at least 25 members and include the printed name, signature, address, telephone number, and email address of an officer or designee of the association.

c. A request by an agency or governmental subdivision shall contain the printed name, signature, address, telephone number, and email address of an officer having authority to act on behalf of the entity.

[ARC 3641C; IAB 2/14/18, effective 3/21/18; Editorial change: IAC Supplement 6/29/22]

657—28.5(17A) Public hearing proceedings.

28.5(1) Applicability. This rule applies only to those public hearings in which an opportunity to make oral presentations is authorized or required by Iowa Code section 17A.4(1) "b."

28.5(2) Scheduling and notice. A public hearing on a proposed rule may be held in one or more locations and shall not be held earlier than 20 days after notice of its location and time is published in the IAB. That notice shall also identify the proposed rule by ARC number and citation to the IAB.

28.5(3) Presiding officer. The board, a member of the board, or another person designated by the board who will be familiar with the substance of the proposed rule, shall preside at the oral proceeding on a proposed rule. If the board does not preside, the presiding officer shall prepare a memorandum for consideration by the board summarizing the contents of the presentations made at the oral proceeding unless the board determines that such a memorandum is unnecessary because the board will personally listen to or read the entire transcript of the oral proceeding.

28.5(4) Conduct of hearing. At a public hearing on a proposed rule, persons may make oral statements and make documentary and physical submissions, which may include data, views, comments or arguments concerning the proposed rule. Persons wishing to make oral presentations at such a proceeding are encouraged to notify the board at least one business day prior to the hearing and indicate the general subject of their presentations. At the hearing, those who participate shall indicate their names and addresses, identify any persons or organizations they may represent, and provide any other information relating to their participation deemed appropriate by the presiding officer. Hearings shall be open to the public and shall be recorded by stenographic or electronic means.

a. At the beginning of the public hearing, the presiding officer shall give a brief synopsis of the proposed rule, a statement of the statutory authority for the proposed rule, and the reasons for the board decision to propose the rule. The presiding officer may place time limitations on individual oral presentations when necessary to ensure the orderly and expeditious conduct of the hearing. To encourage joint oral presentations and to avoid repetition, additional time may be provided for persons whose presentations represent the views of other individuals as well as their own views.

b. Persons making oral presentations are encouraged to avoid restating matters which have already been submitted in writing.

c. To facilitate the exchange of information, the presiding officer may, where time permits, open the floor to questions or general discussion.

d. The presiding officer shall have the authority to take any reasonable action necessary for the orderly conduct of the meeting.

e. Physical and documentary submissions presented by participants in the hearing shall be submitted to the presiding officer. Such submissions become the property of the board.

f. The hearing may be continued by the presiding officer to a later time without notice other than by announcement at the hearing.

g. Participants in a public hearing shall not be required to take an oath or to submit to cross-examination. However, the presiding officer in a hearing may question participants and permit the questioning of participants by other participants about any matter relating to that rule-making proceeding, including any prior written submissions made by those participants in that proceeding; but no participant shall be required to answer any question.

h. The presiding officer in a hearing may permit rebuttal statements and request the filing of written statements subsequent to the adjournment of the oral presentations.
28.5(5) Additional information. In addition to receiving written comments and oral presentations on a proposed rule according to the provisions of this rule, the board may obtain information concerning a proposed rule through any other lawful means deemed appropriate under the circumstances.

28.5(6) Accessibility. The board shall schedule public hearings in rooms accessible to and functional for persons with physical disabilities. Persons who have special requirements should contact the board, telephone (515)281-5944, in advance to arrange access or other needed services.

[ARC 3641C, IAB 2/14/18, effective 3/21/18]

657—28.6(17A) Regulatory analyses.

28.6(1) Definition of small business. A “small business” is defined in Iowa Code section 17A.4A(8) “a.”

28.6(2) Regulatory analysis—economic impact. The board shall issue a regulatory analysis of a proposed board rule in response to a written request from the ARC or the ARRC. The regulatory analysis shall conform to the requirements of Iowa Code section 17A.4A.

28.6(3) Regulatory analysis—business impact. The board shall issue a regulatory analysis of a proposed board rule in response to a written request from one of the following. The regulatory analysis shall conform to the requirements of Iowa Code section 17A.4A.

a. The administrative rules review committee;

b. The administrative rules coordinator;

c. At least 25 or more persons who sign the request provided that each represents a different small business;

d. An organization representing at least 25 small businesses. That organization shall list the name, address, and telephone number of not less than 25 small businesses it represents.

28.6(4) Time period for analysis. Upon receipt of a timely request for a regulatory analysis, the board shall adhere to the time lines described in Iowa Code section 17A.4A.

28.6(5) Contents of request. A request for a regulatory analysis is made when it is mailed or delivered to the board. The request shall be in writing and satisfy the requirements of Iowa Code section 17A.4A.

28.6(6) Contents of concise summary. The contents of the concise summary shall conform to the requirements of Iowa Code section 17A.4A.

28.6(7) Publication of a concise summary. The board shall make available, to the maximum extent feasible, copies of the published summary in conformance with Iowa Code section 17A.4A.

28.6(8) Jobs impact statement. Pursuant to Iowa Code section 17A.4B, the board shall include in the preamble of each rule making a jobs impact statement, unless such statement is waived by the ARC. The board may seek and shall accept public comments and information from stakeholders relating to a jobs impact statement.

[ARC 3641C, IAB 2/14/18, effective 3/21/18]


28.7(1) A proposed rule that mandates additional combined expenditures exceeding $100,000 by all affected political subdivisions or agencies and entities which contract with political subdivisions to provide services shall be accompanied by a fiscal impact statement outlining the costs associated with the rule. A fiscal impact statement shall satisfy the requirements of Iowa Code section 25B.6.

28.7(2) If the board determines at the time it adopts a rule that the fiscal impact statement upon which the rule is based contains errors, the board shall, at the same time, issue a corrected fiscal impact statement and publish the corrected fiscal impact statement in the Iowa Administrative Bulletin.

[ARC 3641C, IAB 2/14/18, effective 3/21/18]

657—28.8(17A) Time and manner of rule adoption.

28.8(1) Time of adoption. At least 35 days following publication of a Notice of Intended Action, the board may adopt a rule or terminate the rule making. Within 180 days after the date of publication of the notice or the deadline for public comments, whichever is later, the board shall adopt a rule or terminate the proceeding. Subsequent actions shall be published in the Iowa Administrative Bulletin.
28.8(2) Consideration of public comment. Before the adoption of a rule, the board shall consider fully all of the written submissions and oral submissions received in that rule-making proceeding, or any memorandum summarizing such oral submissions, and any regulatory analysis, jobs impact statement, or fiscal impact statement issued in that rule-making proceeding.

28.8(3) Reliance on board expertise. Except as otherwise provided by law, the board may use its own experience, technical competence, specialized knowledge, and judgment in the adoption of a rule.

657—28.9(17A) Variance between adopted rule and published notice of proposed rule adoption.

28.9(1) The board shall not adopt a rule that differs from the rule proposed in the Notice of Intended Action on which the rule is based unless:

a. The differences are within the scope of the subject matter announced in the Notice of Intended Action and are in character with the issues raised in that notice; and

b. The differences are a logical outgrowth of the contents of that Notice of Intended Action and the comments submitted in response thereto; and

c. The Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question.

28.9(2) In determining whether the Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question, the board shall consider the following factors:

a. The extent to which persons who will be affected by the rule should have understood that the rule-making proceeding on which it is based could affect their interests;

b. The extent to which the subject matter of the rule or the issues determined by the rule are different from the subject matter or issues contained in the Notice of Intended Action; and

28.9(3) Concurrent rule-making proceedings. Nothing in this rule disturbs the discretion of the board to initiate, concurrently, several different rule-making proceedings on the same subject with several different published Notices of Intended Action.

657—28.10(17A) Exemptions from public rule-making procedures.

28.10(1) Emergency-adopted rule. To the extent the board for good cause finds that public notice and participation are unnecessary, impracticable, or contrary to the public interest in the process of adopting a particular rule, and with the prior approval of the ARRC and ARC, or if a statute so provides, the board may adopt that rule without publishing advance Notice of Intended Action in the Iowa Administrative Bulletin and without providing for written or oral public submissions prior to its adoption. The board shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

28.10(2) Notice of emergency-adopted rule. The board may, at any time, begin a standard rule-making proceeding for the adoption of a rule that is emergency-adopted without notice pursuant to subrule 28.10(1) and that is identical or similar to a rule it adopts in reliance upon subrule 28.10(1). After notice commenced pursuant to this subrule, the board may either readopt the rule it emergency-adopted without benefit of all usual procedures on the basis of subrule 28.10(1) or may take any other lawful action, including the amendment or repeal of the rule in question, with whatever further proceedings are appropriate.

657—28.11(17A) Concise statement of reasons. When requested by a person, either prior to the adoption of a rule or within 30 days after its publication in the Iowa Administrative Bulletin as an adopted rule, the board shall issue a concise statement of reasons for the rule pursuant to Iowa Code section 17A.4(2). Requests for such a statement shall be in writing and be delivered to the Iowa Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. The request shall indicate
whether the statement is sought for all or only a specified part of the rule. Requests will be considered made on the date received.

[ARC 3641C, IAB 2/14/18, effective 3/21/18]

657—28.12(17A) Style and form. In preparing its rules, the board shall follow the uniform numbering system, form, and style prescribed by the administrative rules coordinator.

[ARC 3641C, IAB 2/14/18, effective 3/21/18]

657—28.13(17A) Board rule-making record.

28.13(1) Requirement. The board shall maintain an official rule-making record for each rule it proposes by publication in the Iowa Administrative Bulletin of a Notice of Intended Action or adopts. The rule-making record and materials incorporated by reference shall be available for public inspection.

28.13(2) Contents. The board rule-making record shall contain:

a. Copies of all publications in the Iowa Administrative Bulletin with respect to the rule or the proceeding upon which the rule is based;

b. All written petitions, requests, and submissions received by the board, and all other written materials of a factual nature as distinguished from opinion that are relevant to the merits of the rule and that were created or compiled by the board and considered by the board, in connection with the formulation, proposal, or adoption of the rule or the proceeding upon which the rule is based, except to the extent the board is authorized by law to keep them confidential; provided, however, that when any such materials are deleted because they are authorized by law to be kept confidential, the board shall identify in the record the particular materials deleted and state the reasons for that deletion;

c. Any official transcript of oral presentations made in the proceeding upon which the rule is based or, if not transcribed, the stenographic record or electronic recording of those presentations, and any memorandum prepared by a presiding officer summarizing the contents of those presentations;

d. A copy of any regulatory analysis or fiscal impact statement;

e. A copy of the rule and any concise statement of reasons prepared for that rule;

f. All petitions for amendment of, or repeal or suspension of, the rule;

g. A copy of any objection to the rule filed by the administrative rules review committee, the governor, or the attorney general pursuant to Iowa Code section 17A.4(6), and any board response to that objection;

h. A copy of any significant written criticism of the rule, including a summary of any petitions for waiver of the rule; and

i. A copy of any executive order concerning the rule.

28.13(3) Effect of record. Except as otherwise required by a provision of law, the board rule-making record required by this rule need not constitute the exclusive basis for board action on that rule.

28.13(4) Maintenance of record. The board shall maintain the rule-making record for a period of not less than five years from the later of the date the rule to which it pertains became effective or the date of the Notice of Intended Action. The board shall maintain a record of significant written criticism as described in paragraph 28.13(2) “g,” “h,” or “i,” for a period of not less than five years from the date of the written criticism.

[ARC 3641C, IAB 2/14/18, effective 3/21/18]

657—28.14(17A) Filing of rules. The board shall file each rule the board adopts with the office of the administrative rules coordinator. The filing shall be executed as soon after adoption of the rule as is practicable. In filing a rule, the board shall use the standard form prescribed by the administrative rules coordinator.

[ARC 3641C, IAB 2/14/18, effective 3/21/18]

657—28.15(17A) Effectiveness of rules prior to publication.

28.15(1) Grounds. The board may make a rule effective after its filing at any stated time prior to 35 days after its indexing and publication in the Iowa Administrative Bulletin if it finds that a statute so provides, the rule confers a benefit or removes a restriction on some segment of the public, or that the
effective date of the rule is necessary to avoid imminent peril to the public health, safety, or welfare. The board shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

28.15(2) Special notice. When the board makes a rule effective prior to its indexing and publication in reliance upon the provisions of Iowa Code section 17A.5(2) “b,” the board shall employ all reasonable efforts to make its contents known to the persons who may be affected by that rule prior to the rule’s indexing and publication. The term “all reasonable efforts” requires the board to employ the most effective and prompt means of notice rationally calculated to inform potentially affected parties of the effectiveness of the rule that is justified and practical under the circumstances considering the various alternatives available for this purpose, the comparative costs to the board of utilizing each of those alternatives, and the harm suffered by affected persons from any lack of notice concerning the contents of the rule prior to its indexing and publication.

657—28.16(17A) Review by board of rules. Over each five-year period of time beginning July 1, 2012, the board shall conduct an ongoing and comprehensive review of all the board’s rules pursuant to Iowa Code section 17A.7(2). The purpose of the review is to identify and eliminate all rules that are outdated, redundant, or inconsistent or incompatible with statute, other board rules, or rules of other agencies. When the board’s five-year review of its rules is completed, the board shall summarize the results and provide the summary to the ARC and the ARRC.

These rules are intended to implement Iowa Code sections 17A.1 through 17A.9A. 
[Filed 5/21/92, Notice 4/1/92—published 6/10/92, effective 7/15/92] 
[Filed ARC 3641C (Notice ARC 3373C, IAB 10/11/17), IAB 2/14/18, effective 3/21/18] 
[Editorial change: IAC Supplement 6/29/22]
CHAPTER 29
SALES OF GOODS AND SERVICES

657—29.1(68B) Selling of goods or services by members of the board. The board members shall not sell, either directly or indirectly, any goods or services to individuals, associations, or corporations that are subject to the regulatory authority of the board of pharmacy except as authorized by these rules.

[ARC 3346C, IAB 9/27/17, effective 11/1/17]

657—29.2(68B) Conditions of consent for board members. Consent shall be given by a majority of the members of the board. Consent shall not be given to a board member to sell goods or services to an individual, association, or corporation regulated by the board unless all of the following conditions are met:

1. The board member requesting consent does not have authority to determine whether consent should be given.
2. The board member’s duties or functions are not related to the board’s regulatory authority over the individual, association, or corporation to whom the goods and services are being sold, or the selling of the good or service does not affect the board member’s duties or functions.
3. The selling of the good or service does not include acting as an advocate on behalf of the individual, association, or corporation to the board.
4. The selling of the good or service does not result in the board member selling a good or service to the board on behalf of the individual, association, or corporation.

[Editorial change: IAC Supplement 6/29/22]

657—29.3(68B) Authorized sales.
29.3(1) A member of the board may sell goods or services to any individual, association, or corporation regulated by any division within the department of public health, other than the board of pharmacy. This consent is granted because the sale of such goods or services does not affect the board member’s duties or functions on the board.

29.3(2) A member of the board may sell goods or services to any individual, association, or corporation regulated by the board of pharmacy if those goods or services are routinely provided to the public as part of that person’s regular professional practice. This consent is granted because the sale of such goods or services does not affect the board member’s duties or functions on the board. In the event an individual, association, or corporation to whom a board member sells goods or services is directly involved in any matter pending before the board, including a disciplinary matter, that board member shall not participate in any deliberation or decision concerning that matter. In the event a complaint is filed with the board concerning the services provided by the board member to a member of the public, that board member is otherwise prohibited by law from participating in any discussion or decision by the board in that case.

29.3(3) Individual application and approval are not required for the sales authorized by this rule unless there are unique facts surrounding a particular sale which would cause the sale to affect the board member’s duties or functions, would give the buyer an advantage in dealing with the board, or would otherwise present a conflict of interest.

[ARC 3346C, IAB 9/27/17, effective 11/1/17]

657—29.4(68B) Application for consent. Prior to selling a good or service to an individual, association, or corporation subject to the regulatory authority of the board of pharmacy, a board member must obtain prior written consent unless the sale is specifically allowed in rule 657—29.3(68B). The request for consent must be in writing, signed by the board member requesting consent. The application must provide a clear statement of all relevant facts concerning the sale. The application should identify the parties to the sale and the amount of compensation. The application should also explain why the sale should be allowed.

[ARC 3346C, IAB 9/27/17, effective 11/1/17]
657—29.5(68B) **Limitation of consent.** Consent shall be in writing and shall be valid only for the activities and the time period specifically described in the consent. Consent can be revoked at any time by a majority vote of the members of the board upon written notice to the board member. A consent provided under these rules does not constitute authorization for any activity which is a conflict of interest under common law or which would violate any other statute or rule.

It is the responsibility of the board member requesting consent to ensure compliance with all other applicable laws and rules.

These rules are intended to implement Iowa Code section 68B.4.


[Filed ARC 3346C (Notice ARC 3133C, IAB 6/21/17), IAB 9/27/17, effective 11/1/17]

[Editorial change: IAC Supplement 6/29/22]
CHAPTER 68
MOTOR FUEL AND UNDYED SPECIAL FUEL
[Prior to 1/1/96, see 701—Ch 64]

701—68.1(452A) Definitions. See 701—67.1(452A).

701—68.2(452A) Tax rates—time tax attaches—responsible party.

68.2(1) The following rates of tax apply to the use of fuel in operating motor vehicles and aircraft:

<table>
<thead>
<tr>
<th>Fuel Type</th>
<th>Rate and Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gasoline</td>
<td>30.7¢ per gallon (for July 1, 2016, through June 30, 2017)</td>
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<td></td>
<td>30.5¢ per gallon (for July 1, 2017, through June 30, 2018)</td>
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<tr>
<td></td>
<td>30.7¢ per gallon (for July 1, 2018, through June 30, 2019)</td>
</tr>
<tr>
<td></td>
<td>30.5¢ per gallon (for July 1, 2019, through June 30, 2020)</td>
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<tr>
<td></td>
<td>30¢ per gallon (beginning July 1, 2020)</td>
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<tr>
<td>Ethanol blended gasoline</td>
<td>29¢ per gallon (for July 1, 2016, through June 30, 2020)</td>
</tr>
<tr>
<td>Ethanol blended gasoline E-10 to E-14</td>
<td>30¢ per gallon (beginning July 1, 2020)</td>
</tr>
<tr>
<td>E-85 gasoline</td>
<td>29¢ per gallon (for July 1, 2016, through June 30, 2020)</td>
</tr>
<tr>
<td>Ethanol blended gasoline E-15 or higher</td>
<td>24¢ per gallon (beginning July 1, 2020)</td>
</tr>
<tr>
<td>Aviation gasoline</td>
<td>8¢ per gallon (beginning July 1, 1988)</td>
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<td>Diesel fuel other than B-11 or higher</td>
<td>22.5¢ per gallon (on and before February 28, 2015)</td>
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<td>32.5¢ per gallon (beginning March 1, 2015)</td>
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<tr>
<td>Biodiesel blended fuel (B-11 or higher)</td>
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<td></td>
<td>30.1¢ per gallon (for July 1, 2020, through June 30, 2021)</td>
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<td>30.1¢ per gallon (beginning July 1, 2022)</td>
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<td>Aviation jet fuel</td>
<td>3¢ per gallon (on and before February 28, 2015)</td>
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<td>5¢ per gallon (beginning March 1, 2015)</td>
</tr>
<tr>
<td>L.P.G.</td>
<td>20¢ per gallon (on and before February 28, 2015)</td>
</tr>
<tr>
<td></td>
<td>30¢ per gallon (beginning March 1, 2015)</td>
</tr>
<tr>
<td>C.N.G.</td>
<td>16¢ per 100 cu. ft. (on and before June 30, 2014)</td>
</tr>
<tr>
<td></td>
<td>21¢ per gallon (for July 1, 2014, through February 28, 2015)</td>
</tr>
<tr>
<td></td>
<td>31¢ per gallon (beginning March 1, 2015)</td>
</tr>
<tr>
<td>L.N.G.</td>
<td>22.5¢ per gallon (on and before February 28, 2015)</td>
</tr>
<tr>
<td></td>
<td>32.5¢ per gallon (beginning March 1, 2015)</td>
</tr>
</tbody>
</table>

68.2(2) Fuel distribution percentages.

a. Ethanol distribution percentage.

(1) Except as otherwise provided in this paragraph, this paragraph shall apply to the excise tax imposed on each gallon of motor fuel used for any purpose for the privilege of operating motor vehicles in this state. An excise tax of 30 cents is imposed on each gallon of motor fuel other than ethanol blended gasoline classified as E-15 or higher.

(2) On and after July 1, 2026, an excise tax of 30 cents is imposed on each gallon of ethanol blended gasoline classified as E-15 or higher.

(3) Before July 1, 2026, the rate of the excise tax on ethanol blended gasoline classified as E-15 or higher shall be based on the ethanol distribution percentage as specified in Iowa Code section 452A.3. The ethanol distribution percentage is the number of gallons of ethanol blended gasoline classified as E-15 or higher that are distributed in this state as expressed as a percentage of the number of gallons of motor fuel, excluding aviation gasoline, distributed in this state. The department shall determine the percentage for each determination period beginning January 1 and ending December 31 based on data
from reports filed pursuant to Iowa Code section 452A.33. The rate for the excise tax shall apply for the period beginning July 1 and ending June 30 following the end of the determination period.

b. Biodiesel distribution percentage.

(1) Except as otherwise provided in this paragraph, the rate of the excise tax on each gallon of special fuel for diesel engines of motor vehicles used for any purpose for the privilege of operating motor vehicles in this state, other than biodiesel blended fuel classified as B-11 or higher, is 32.5 cents.

1. Except as otherwise provided in this paragraph, this paragraph shall apply to the excise tax imposed on each gallon of biodiesel blended fuel classified as B-11 or higher used for any purpose for the privilege of operating motor vehicles in this state.

2. On and after July 1, 2026, the rate of the excise tax on each gallon of biodiesel blended fuel classified as B-11 or higher is 32.5 cents.

3. Before July 1, 2026, the rate of the excise tax shall be based on the biodiesel distribution percentage as specified in Iowa Code section 452A.3. The biodiesel distribution percentage is the number of gallons of biodiesel blended fuel classified as B-11 or higher that is distributed in this state as expressed as a percentage of the number of gallons of special fuel for diesel engines of motor vehicles distributed in this state. The department shall determine the percentage for each determination period beginning January 1 and ending December 31 based on data from reports filed pursuant to Iowa Code section 452A.33. The rate for the excise tax shall apply for the period beginning July 1 and ending June 30 following the end of the determination period.

(2) The determination period for the biodiesel distribution percentage is January through December each calendar year.

c. Legislative review. The ethanol distribution percentage, the biodiesel distribution percentage, and the corresponding excise tax rates are subject to legislative review at least every five years. The review is based upon a fuel distribution percentage formula status report, which contains the recommendations of a legislative interim committee appointed to conduct a review of the fuel distribution percentage formulas. The report is prepared with the assistance of the Iowa department of revenue and the Iowa department of transportation. The report includes recommendations for changes or revisions to the fuel distribution percentage formulas based upon advances in technology, fuel use trends, and fuel price fluctuations observed during the preceding five-year interval; an analysis of the operation of the fuel distribution percentage formulas during the preceding five-year interval; and a summary of issues that have arisen since the previous review and potential approaches for resolution of those issues. The first report will be submitted to the general assembly no later than January 1, 2020, with subsequent reports developed and submitted by January 1 at least every fifth year thereafter.

68.2(3) The tax attaches when the fuel is withdrawn from a terminal or imported into Iowa. The tax is payable to the department by the supplier, restrictive supplier, importer, blender, or any person who owns the fuel at the time it is brought into the state by a restrictive supplier or importer or any other person who possesses taxable fuel upon which the tax has not been paid. The tax is to be remitted to the department by a supplier, restrictive supplier, or blender by the last day of the month following the month in which the fuel is withdrawn from a terminal or imported. The tax is to be remitted by an importer by the last day of the month for fuel imported in the first 15 days of the month and by the fifteenth day of the following month for fuel imported after the fifteenth day of the previous month. Nonlicensees who possess taxable fuel upon which the tax has not been paid must file returns and pay the tax the same as a restrictive supplier (monthly). All licensees must make payment by electronic funds transfer (see publication 90-201 for EFT requirements).

68.2(4) Persons having title to motor fuel, ethanol blended gasoline, undyed special fuel, compressed natural gas, liquefied natural gas, or liquefied petroleum gas in storage and held for sale on the effective date of an increase in the excise tax rate imposed on motor fuel, ethanol blended gasoline, undyed special fuel, compressed natural gas, liquefied natural gas, or liquefied petroleum gas shall be subject to an inventory tax based upon the gallonage in storage as of the close of the business day preceding the effective date of the increased excise tax rate of motor fuel, ethanol blended gasoline, undyed special fuel, compressed natural gas, liquefied natural gas, or liquefied petroleum gas which will be subject to the increased excise tax rate.
a. Persons subject to the tax imposed under this subrule shall take an inventory to determine the gallonage in storage for purposes of determining the tax and shall report the gallonage and pay the tax due within 30 days of the prescribed inventory date.

b. The amount of the inventory tax is equal to the inventory tax rate times the gallonage in storage. The inventory tax rate is equal to the increased excise tax rate less the previous excise tax rate. The inventory tax does not apply to an increase in the tax rate of a specified fuel, except for compressed natural gas, unless the increase in the tax rate of that fuel is in excess of one-half cent per gallon.

This rule is intended to implement Iowa Code sections 452A.3, 452A.8 and 452A.85.

[ARC 8225B, IAB 1/7/09, effective 11/11/09; ARC 0399C, IAB 10/17/12, effective 11/21/12; ARC 1442C, IAB 4/30/14, effective 6/4/14; ARC 1805C, IAB 1/7/15, effective 2/11/15; ARC 2247C, IAB 11/25/15, effective 12/30/15; ARC 2698C, IAB 8/31/16, effective 10/5/16; ARC 3146C, IAB 6/21/17, effective 7/26/17; ARC 4252C, IAB 1/16/19, effective 2/20/19; ARC 4585C, IAB 7/31/19, effective 9/4/19; ARC 5842C, IAB 8/11/21, effective 9/15/21; ARC 6395C, IAB 6/29/22, effective 8/3/22]

701—68.3(452A) Exemption.

68.3(1) Motor fuel or undyed special fuel sold for export or exported from this state to another state, territory, or foreign country is exempt from the excise tax. The fuel is deemed sold for export or exported only if the bill of lading or manifest indicates that the destination of the fuel withdrawn from the terminal is outside the state of Iowa. The mode of transportation is not of consequence. In the event fuel is taxed and then subsequently exported, an amount equal to the tax previously paid will be allowable as a refund, upon receipt by the department of the appropriate documents, to the party who originally paid the tax. If the sale of exported fuel is completed in Iowa, then the sale is subject to Iowa sales tax if it is not exported for resale or otherwise exempt from sales tax. The sale is completed in Iowa if the foreign purchaser takes physical possession of the fuel in this state. See sales tax rule 701—18.37(422,423).

68.3(2) Indelible dye meeting United States Environmental Protection Agency and Internal Revenue Service regulations must be added to fuel before or upon withdrawal at a terminal or refinery rack for that fuel to be exempt from tax and the dyed fuel can only be used for a nontaxable purpose listed in Iowa Code section 452A.17(1) ‘a.’ “ However, this exemption does not apply to fuel used for idle time, power takeoffs, reefer units, or pumping credits, or fuel used by contract carriers.

This rule is intended to implement Iowa Code section 452A.3 as amended by 1995 Iowa Acts, chapter 155.

[ARC 5842C, IAB 8/11/21, effective 9/15/21]

701—68.4(452A) Blended fuel taxation—nonterminal location.

68.4(1) Responsibilities of all blenders at nonterminal locations. A person who blends ethanol blended gasoline or biodiesel blended fuel at a nonterminal location must obtain a blender’s license. Blending ethanol with gasoline, or blending biodiesel with petrodiesel, may result in additional tax due or an allowable refund depending on the ethanol content of the mixture and the tax paid on its components. The blender must make payment to the department for the additional tax due. The blender must obtain a refund permit to receive a refund of the overpayment of tax on the blended product.

EXAMPLE 1. A blender blends three parts ethanol with 17 parts gasoline to create E-15. The E-15 is taxed as ethanol blended gasoline, and the blender may be due a refund for excess tax paid on the gasoline used.

EXAMPLE 2. A blender blends one part biodiesel with four parts petrodiesel to create B-20. The B-20 is taxed as B-11 or higher, and the blender may be due a refund for excess tax paid on the petrodiesel used.

EXAMPLE 3. A blender blends one part biodiesel with 19 parts petrodiesel to create B-5. The B-5 is taxed as diesel other than B-11 or higher, and the blender may owe additional tax to the department on the biodiesel used.

EXAMPLE 4. A blender blends one part B-20 with five parts B-2 to create B-5. The B-5 is taxed as diesel other than B-11 or higher, and the blender may owe additional tax to the department on the B-20 used.

68.4(2) Blenders of ethanol blended gasoline.
A blender who owns the ethanol (supplier) being used to blend with gasoline must purchase the gasoline from a supplier and pay the appropriate tax to the supplier. The blender must obtain a blender’s license and compute the tax due on the total gallons of blended product and make payment to the department for the additional amount due. For purposes of the following example, the tax rate for gasoline is presumed to be 30¢ per gallon and the tax rate for ethanol blended gasoline E-15 or higher is presumed to be 24¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1).

**Example:**

Blender purchases 7,000 gallons tax-paid gasoline (7,000 × .30) = $2,100.00
Blender adds 3,000 gallons untaxed ethanol
Total tax paid on products $2,100.00
Total tax due on 10,000 gallons ethanol blended gasoline E-15 or higher (10,000 × .24) = $2,400.00
Additional Amount Due $300.00

A blender who purchases ethanol and gasoline from a supplier must pay tax on both the ethanol purchased and the gasoline purchased. The blender must obtain a refund permit to receive a refund of the overpayment of tax on the blended product. For purposes of the following example, the tax rate for gasoline is presumed to be 30¢ per gallon and the tax rate for ethanol blended gasoline E-15 or higher is presumed to be 24¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1).

**Example:**

Blender purchases 7,000 gallons tax-paid gasoline (7,000 × .30) = $2,100.00
Blender purchases 3,000 gallons tax-paid ethanol (3,000 × .24) = $720.00
Total tax paid on products $2,820.00
Total tax due on 10,000 gallons ethanol blended gasoline E-15 or higher (10,000 × .24) = $2,400.00
Amount of Refund Allowable $420.00

A blender who purchases ethanol and gasoline from any source must pay tax on both the ethanol purchased and the gasoline purchased. The blender must obtain a blender’s license and compute the tax due on the total gallons of blended product and make payment to the department for the additional amount due. For purposes of the following example, the tax rate for gasoline is presumed to be 30¢ per gallon, the tax rate for ethanol is presumed to be 24¢ per gallon, and the tax rate for ethanol blended gasoline E-10 is presumed to be 30¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1).

**Example:**

Blender purchases 7,200 gallons tax-paid gasoline (7,200 × .30) = $2,160.00
Blender purchases 800 gallons tax-paid ethanol (800 × .24) = $192.00
Total tax paid on products $2,352.00
Total tax due on 8,000 gallons ethanol blended gasoline E-10 (8,000 × .30) = $2,400.00
Additional Amount Due $48.00

A blender who purchases ethanol blended gasoline E-10 to E-14 and ethanol blended gasoline E-15 or higher from a supplier must pay tax on both the ethanol blended gasoline E-10 to E-14 purchased...
and the ethanol blended gasoline E-15 purchased. The blender must obtain a refund permit to receive a refund of the overpayment of tax on the blended product. For purposes of the following example, the tax rate for E-10 to E-14 purchased is presumed to be 30¢ per gallon and the tax rate for ethanol blended gasoline E-15 or higher is presumed to be 24¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1).

**EXAMPLE:**

Blender purchases 7,000 gallons tax-paid ethanol blended gasoline E-10 to E-14 (7,000 × .30) = $2,100.00

Blender purchases 3,000 gallons tax-paid ethanol blended gasoline E-15 or higher (3,000 × .24) = $720.00

Total tax paid on products = $2,820.00

Total tax due on 10,000 gallons ethanol blended gasoline E-15 or higher (10,000 × .24) = $2,400.00

Amount of Refund Allowable = $420.00

e. Ethanol blended gasoline E-15 or higher—blending errors.

Where a blending error occurs and an insufficient amount of ethanol has been blended with gasoline so that the mixture fails to qualify as ethanol blended gasoline E-15 or higher, a 1 percent tolerance applies in determining the tax on the blended product as described in this paragraph:

1. If the amount of the ethanol erroneously blended with gasoline is at least 14 percent of the total blended product by volume, the ethanol and gasoline blended product is considered ethanol blended gasoline E-15 or higher and there is no penalty or assessment of additional tax.

2. If the amount of ethanol erroneously blended with gasoline is less than 14 percent of the total blended product by volume, the total blend of gasoline and ethanol is subject to tax as ethanol blended gasoline E-10 to E-14 at the prevailing rate of tax.

3. This paragraph applies only if a blender intends to produce ethanol blended gasoline E-15 or higher. If a blender does not intend to produce ethanol blended gasoline when blending ethanol and gasoline, and the mixture contains less than 14 percent ethanol by volume, no error has occurred and the mixture is subject to tax as ethanol blended gasoline E-10 to E-14.

4. The following formulas are used to compute blending errors:

   Actual gasoline + actual ethanol = total gallons of blended product
   
   Total gallons of blended product × .14 = required ethanol

5. Examples. The following factors are assumed for all examples:

   The blender in each example intends to blend ethanol blended gasoline E-15 or higher. Figures are rounded to the nearest whole gallon; ethanol blended gasoline E-15 or higher is taxed at 24¢ per gallon; gasoline is taxed at 30¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1). Penalty and interest charges are not computed in the examples.

**EXAMPLE 1:**

Actual gasoline = 8,500 gal.

Actual ethanol = 1,500 gal.

Total blended product = 10,000 gal.

10,000 × .14 = 1,400 gal. required ethanol

The actual ethanol (1,500 gallons) is more than the required ethanol (1,400 gallons), which means that the tax is applied according to subparagraph 68.4(2)“e”(1) as follows:

10,000 gal. of blended product × .24 = $2,400 tax on ethanol blended gasoline E-15 or higher
EXAMPLE 2:
Actual gasoline = 9,200 gal.
Actual ethanol = 800 gal.
Total blended product = 10,000 gal.
10,000 × .14 = 1,400 gal. required ethanol

The actual ethanol (800 gallons) is less than the required ethanol (1,400 gallons), which means that the entire blend is considered gasoline and the tax is applied according to subparagraph 68.4(2)”e”(2) as follows:

10,000 gal. of blended product × .30 = $3,000 tax on gasoline

68.4(3) Blenders of biodiesel blended fuel.
a. A blender who owns the biodiesel being used to blend with diesel must purchase the diesel from a supplier and pay the appropriate tax to the supplier. The blender must obtain a blender’s license and compute the tax due on the total gallons of blended product and make payment to the department for the additional amount due. For purposes of the following examples, the tax rate for B-11 or higher is presumed to be 30.1¢ per gallon and the tax rate for diesel other than B-11 or higher is presumed to be 32.5¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1).

EXAMPLE 1.
Blender purchases 7,120 gallons tax-paid petrodiesel (7,120 × .325) = $2,314.00
Blender adds 880 gallons untaxed biodiesel = $.00
Total tax paid on products = $2,314.00

The blended product is 8,000 gallons of diesel, which includes 880 gallons (11% by volume) of biodiesel. Thus, the product is taxed as B-11 or higher.

Total tax due on 8,000 gallons blended B-11 or higher (8,000 × .301) = $2,408.00
Additional Amount Due = $94.00

EXAMPLE 2.
Blender purchases 7,600 gallons tax-paid petrodiesel (7,600 × .325) = $2,470.00
Blender adds 400 gallons untaxed biodiesel = $.00
Total tax paid on products = $2,470.00

The blended product is 8,000 gallons of diesel, which includes 400 gallons (5% by volume) of biodiesel. Thus, the product is taxed as diesel other than B-11 or higher.

Total tax due on 8,000 gallons diesel other than B-11 or higher (8,000 × .325) = $2,600.00
Additional Amount Due = $130.00

EXAMPLE 3.
Blender purchases 7,750 gallons tax-paid B-2 (7,750 × .325) = $2,518.75
Blender adds 250 gallons untaxed biodiesel = $.00
Total tax paid on products = $2,518.75
7,750 gallons of B-2 contains 155 gallons (2%) of biodiesel. The blended product is 8,000 gallons of diesel, which includes 405 gallons (155 + 250, or 5% by volume) of biodiesel. Thus, the product is taxed as diesel other than B-11 or higher.

Total tax due on 8,000 gallons diesel other than B-11 or higher (8,000 × .325) = $2,600.00
Additional Amount Due = $81.25

b. A blender who purchases diesel products from a supplier must pay the appropriate tax on all diesel products purchased. The blender must obtain a blender’s license and compute the tax due on the total gallons of blended product and make payment to the department for any additional amount due. The blender must also obtain a refund permit to receive a refund of any overpayment of tax on the blended product. For purposes of the following examples, the tax rate for B-11 or higher is presumed to be 30.1¢ per gallon and the tax rate for diesel fuel other than B-11 or higher is presumed to be 32.5¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1).

**Example 1.**
Blender purchases 7,120 gallons tax-paid petrodiesel (7,120 × .325) = $2,314.00
Blender purchases 880 gallons tax-paid biodiesel (880 × .301) = $264.88
Total tax paid on products = $2,578.88

The blended product is 8,000 gallons of diesel, which includes 880 gallons (11% by volume) of biodiesel. Thus, the product is taxed as B-11 or higher.

Total tax due on 8,000 gallons blended B-11 or higher (8,000 × .301) = $2,408.00
Amount of Refund Allowable = $170.88

**Example 2.**
Blender purchases 7,600 gallons tax-paid petrodiesel (7,600 × .325) = $2,470.00
Blender purchases 400 gallons tax-paid biodiesel (400 × .301) = $120.40
Total tax paid on products = $2,590.40

The blended product is 8,000 gallons of biodiesel blended fuel, which includes 400 gallons (5% by volume) of biodiesel. Thus, the product is taxed as diesel other than B-11 or higher.

Total tax due on 8,000 gallons blended B-5 (8,000 × .325) = $2,600.00
Additional Amount Due = $9.60

**Example 3.**
Blender purchases 4,000 gallons tax-paid B-2 (4,000 × .325) = $1,300.00
Blender purchases 4,000 gallons tax-paid B-20 (4,000 × .301) = $1,204.00
Total tax paid on products = $2,504.00

4,000 gallons of B-2 contains 80 gallons (2%) of biodiesel, and 4,000 gallons of B-20 contains 800 gallons (20%) of biodiesel. The blended product is 8,000 gallons of diesel, which includes 880 gallons (80 + 800, or 11% by volume) of biodiesel. Thus, the product is taxed as B-11 or higher.

Total tax due on 8,000 gallons B-11 or higher (8,000 × .301) = $2,408.00
Amount of Refund Allowable = $96.00
c. Blending errors. Where a blending error occurs and an insufficient amount of biodiesel has been blended with petrodiesel so that the mixture fails to qualify as B-11 or higher as defined in rule 701—67.1(452A), a 1 percent tolerance applies in determining the tax on the blended product as described in this paragraph:

(1) If the amount of the biodiesel erroneously blended with petrodiesel is at least 10 percent of the total blended product by volume, the biodiesel and petrodiesel blended product is considered B-11 or higher and there is no penalty or assessment of additional tax.

(2) If the amount of biodiesel blended with petrodiesel is less than 10 percent of the total blended product by volume, the entire mixture is considered taxable diesel other than B-11 or higher and subject to tax at the prevailing rate.

(3) This paragraph applies only if a blender intends to produce B-11 or higher. If a blender does not intend to produce B-11 or higher when blending biodiesel and petrodiesel, and the mixture contains less than 11 percent biodiesel by volume, no error has occurred and the mixture is subject to tax as diesel other than B-11 or higher.

(4) The following formulas are used to compute blending errors:

Actual biodiesel + actual petrodiesel = total gallons of blended product
Total gallons of blended product × .1 = required biodiesel

(5) Examples. The following factors are assumed for all examples:

The blender in each example intends to blend B-11 or higher. Figures are rounded to the nearest whole gallon; B-11 or higher is taxed at .301¢ per gallon; diesel other than B-11 or higher is taxed at .325¢ per gallon. The actual tax rates for the appropriate period are shown in subrule 68.2(1). Penalty and interest charges are not computed in the examples.

**Example 1.**

Actual petrodiesel = 8,095 gal.
Actual biodiesel = 905 gal.
Total blended product = 9,000 gal.
9,000 × .1 = 900 gal. required biodiesel

The actual biodiesel (905 gallons) is more than the required biodiesel (900 gallons). Thus, the tax is applied according to subparagraph 68.4(3)“c”(1) as follows:

9,000 gal. of blended product × .301 = $2,709 tax on B-11 or higher

**Example 2.**

Actual petrodiesel = 8,105 gal.
Actual biodiesel = 895 gal.
Total blended product = 9,000 gal.
9,000 × .1 = 900 gal. required biodiesel

The actual biodiesel (895 gallons) is less than the required biodiesel (900 gallons). Thus, the tax is applied according to subparagraph 68.4(3)“c”(2) as follows:

9,000 gal. of blended product × .325 = $2,925 tax on diesel other than B-11 or higher
Example 3.

A blender erroneously mixes 5,000 gallons of B-2 with 4,500 gallons of B-20 with the intent of creating B-11 or higher. 5,000 gallons of B-2 contains 100 gallons (2%) of biodiesel. 4,500 gallons of B-20 contains 900 gallons (20%) of biodiesel. Thus, the 9,500 gallons \((4,500 + 5,000)\) of blended product includes 1,000 gallons \((100 + 900)\) of biodiesel and 8,500 gallons \((9,500 - 1,000)\) of petrodiesel.

\[
\begin{align*}
\text{Actual petrodiesel} & = 8,500 \text{ gal.} \\
\text{Actual biodiesel} & = 1,000 \text{ gal.} \\
\text{Total blended product} & = 9,500 \text{ gal.} \\
9,500 \times .1 & = 950 \text{ gal. required biodiesel}
\end{align*}
\]

The actual biodiesel \((1,000 \text{ gal.})\) is greater than the required biodiesel \((950 \text{ gal.})\), which means that the entire blend is considered B-11 or higher and the tax is applied according to subparagraph 68.4(3) “c”(1) as follows:

\[
9,500 \text{ gal. of blended product} \times .301 = \$2,859.50 \text{ tax on B-11 or higher}
\]

This rule is intended to implement Iowa Code section 452A.8 as amended by 2015 Iowa Acts, Senate File 257.

[ARC 2247C, IAB 11/25/15, effective 12/30/15; ARC 5842C, IAB 8/11/21, effective 9/15/21]

701—68.5(452A) Tax returns—computations.

68.5(1) Supplier—nexus.

a. The fuel tax liability for a supplier is computed by multiplying the per gallon fuel tax rate by the total number of invoiced gallons of motor fuel or undyed special fuel withdrawn from the terminal by the supplier within the state or by the supplier with an Iowa nexus from a terminal outside the state during the preceding calendar month, less deductions for fuel exported in the case of in-state withdrawals and the distribution allowance provided for in Iowa Code section 452A.5.

Tax shall not be paid when the sale of ethanol occurs within a terminal from an ethanol manufacturer to a licensed supplier. The tax shall be paid by the licensed supplier when the invoiced gross gallonage of the ethanol or the ethanol part of the ethanol blended gasoline is withdrawn from a terminal for delivery in this state. This makes the licensed supplier responsible for the tax on both the ethanol and the gasoline portions of the ethanol blended gasoline and for the reporting and accounting of this fuel as ethanol blended gasoline on the supplier report.

b. If fuel is withdrawn by a supplier with no nexus in Iowa, but who voluntarily agrees to collect and report the tax, from a terminal outside of Iowa for importation into Iowa, the tax liability is computed in the same manner as in paragraph “a” with the exception that no deduction is allowable for exports.

68.5(2) The fuel tax liability for a restrictive supplier is to be computed by multiplying the per gallon fuel tax rate by the total number of invoiced gallons of motor fuel or undyed special fuel imported into Iowa during the preceding calendar month.

68.5(3) The fuel tax liability for an importer is computed by multiplying the per gallon fuel tax rate by the total number of invoiced gallons of motor fuel or undyed special fuel imported into Iowa during the applicable reporting period.

68.5(4) The tax liability for a nonlicensee is computed the same as a restrictive supplier. If motor fuel or undyed special fuel is exported from this state with no tax paid and subsequently returned to this state because all or a portion of it was not delivered where destined, the tax must be paid to the department by the nonlicensee.

All gallon entries on the return for determining the tax liability must be rounded to the nearest whole number.

This rule is intended to implement Iowa Code section 452A.3 as amended by 2001 Iowa Acts, House File 736, and sections 452A.5, 452A.8, and 452A.9.

[ARC 5842C, IAB 8/11/21, effective 9/15/21]
**701—68.6(452A) Distribution allowance.** The tax computation for a supplier includes a distribution allowance of 1.6 percent of the motor fuel gallonage and 0.7 percent of the undyed special fuel gallonage removed from the terminal during the reporting period. The distributor purchasing the fuel from the supplier is entitled to 1.2 percent of the motor fuel distribution allowance. The distributor or dealer purchasing fuel from a supplier is entitled to 0.35 percent of the undyed special fuel distribution allowance. The distribution allowance does not apply to fuel exported.

This rule is intended to implement Iowa Code sections 452A.5 and 452A.8 as amended by 1995 Iowa Acts, chapter 155.

**701—68.7(452A) Supplier credit—uncollectible account.** A licensed supplier who is unable to recover the tax from an eligible purchaser or end user is not liable for the tax and may credit the amount of unpaid tax against a later remittance of tax.

68.7(1) To qualify for the credit, the supplier must notify the department in writing of the uncollectible account no later than ten calendar days after the due date for payment of the tax.

Notification is to be sent to the Iowa Department of Revenue, Compliance Section - Business, P.O. Box 10465, Des Moines, Iowa 50306-0465.

68.7(2) A supplier does not qualify for the credit if the purchaser did not elect to apply for the eligible purchaser or end user status or did not qualify to be an eligible purchaser. Likewise, the credit does not apply if the supplier sells additional fuel to a delinquent eligible purchaser or end user after notifying the department that the supplier has an uncollectible debt with an eligible purchaser.

68.7(3) Upon notification from the supplier that an eligible purchaser is in default of the tax payment, that person’s eligible purchaser or end user status will be canceled by the department. The eligible purchaser or end user status will not be reinstated until such time as the purchaser posts securities to guarantee future tax payments as provided in 701—paragraph 67.21(1) “d.”

68.7(4) Eligible purchaser. Any distributor of motor fuel or special fuel or end user of special fuel who requests authorization to make delayed payments of the motor vehicle fuel tax must first register with the department to obtain the eligible purchaser status.

The eligible purchaser must pay the tax to the supplier by electronic funds transfer one business day prior to the date the tax is to be paid by the supplier.

Once approved, the eligible purchaser status is valid until voluntarily canceled by the eligible purchaser or canceled by the department of revenue. See 701—subrule 67.23(4).

This rule is intended to implement Iowa Code section 452A.8 as amended by 1995 Iowa Acts, chapter 155.

[ARC 5842C, IAB 8/11/21, effective 9/15/21]

**701—68.8(452A) Refunds.** Refunds are allowable for the tax paid on motor fuel and undyed special fuel in the following situations:

68.8(1) Federal government. Fuel sold to the United States or to any agency or instrumentality of the United States. The tax is subject to refund regardless of how the fuel is used.

a. The following factors, among others, will be considered in determining if any organization is an instrumentality of the United States government: (a) whether it was created by the federal government, (b) whether it is wholly owned by the federal government, (c) whether it is operated for profit, (d) whether it is “primarily” engaged in the performance of some “essential” government function, and (e) whether the tax will impose an economic burden upon the federal government or serve to materially impair the usefulness and efficiency of the organization or to materially restrict it in the performance of its duties if it were imposed.

b. The American Red Cross, Project Head Start, Federal Land Banks and Federal Land Bank Associations, among others, have been determined to be instrumentalities of the federal government. Receivers or trustees appointed in the federal bankruptcy proceedings are subject to the excise tax.

The refund is not available to employees of the federal government who purchase fuel individually and are later reimbursed by the federal government. The name of the federal agency must appear on the invoice as the purchaser of the fuel or the refund will not be allowed.
68.8(2) Transit systems. Fuel sold to an Iowa urban transit system as defined in 701—67.1(452A) or a company operating a taxicab service under contract with an Iowa urban transit system which is used for a purpose specified in Iowa Code section 452A.57(6) and fuel sold to a regional transit system as defined in 701—67.1(452A) which is used for a purpose specified in Iowa Code section 452A.57(11).

68.8(3) The state and political subdivisions. Fuel sold to the state of Iowa or any political subdivision of the state which is used for public purposes.
   a. The refund is not available to agencies or instrumentalities of a political subdivision, but rather only to the state of Iowa, agencies of the state of Iowa, and political subdivisions of the state of Iowa. The general attributes and factors in determining if an entity is a political subdivision of the state of Iowa are: (a) the entity has a specific geographic area, (b) the entity has public officials elected at public elections, (c) the entity has taxing power, (d) the entity has a general public purpose or benefit, and (e) the foregoing attributes, factors or powers were delegated to the entity by the state of Iowa.
   b. The refund is also not available to employees of a governmental unit who purchase fuel individually and are later reimbursed by the governmental unit. The name of the governmental unit must appear on the invoice as the purchaser of the fuel or the refund will not be allowed.

68.8(4) Contract carriers.
   a. Motor fuel and undyed special fuel sold to a contract carrier who has a contract with a public school under Iowa Code section 285.5 for the transportation of pupils of an approved public or nonpublic school is refundable. If the contract carrier also uses fuel for purposes other than the transportation of pupils, the refund will be based on that percentage of the total amount of fuel purchased which reflects the pupil transportation usage.
   b. A refund requested by contract carriers will be reduced by the applicable sales tax unless otherwise exempt. The name of the contract carrier must appear on the invoice as the purchaser of the fuel or the refund will not be allowed.

68.8(5) Fuel used in unlicensed vehicles, stationary engines, machinery and equipment used for nonhighway purposes, implements used in agricultural production, and fuel used for home heating.

68.8(6) Fuel used for producing denatured ethanol.

68.8(7) Fuel used in the watercraft of a commercial fisher, licensed and operating under an owner’s certificate for commercial fishing gear issued pursuant to Iowa Code section 482.4.

68.8(8) Fuel placed in motor vehicles, whether registered or not registered, not operated on public highways, and used in the extraction and processing of natural deposits.

68.8(9) Idle time. Persons who wish to claim a refund for idle time (the engine is running but not propelling the vehicle) must first apply to the department and provide statistical information on how the refund amount will be calculated. Normally, to qualify for a refund the vehicle must be equipped with an on-board monitoring device which will record the actual time the engine is idling and the amount of fuel consumed while idling. If the device only records the idle time and not fuel used, the refund amount will be calculated at one-half gallon of fuel consumed per one hour of idle time. The computation must also consider the miles driven in Iowa versus total miles driven. The department will require a review of interstate carrier reports before approval of the computation method.

68.8(10) Power takeoff. Persons operating vehicles which have auxiliary equipment that is powered by the power takeoff may apply for a refund for that portion of the fuel used for powering the auxiliary equipment.

The person requesting the refund must furnish the department with statistical information on how the exempt percentage is established. The percentage can be established by using the following noninclusive methods.

• Determine the actual fuel usage by the hour while the auxiliary equipment is in use compared to total hours the engine is running.
• Establish total miles per gallon for the vehicle when auxiliary equipment is not in use compared to miles per gallon while the equipment is in use.
• Other computation methods to be reviewed by the department prior to approval.

It has been predetermined that tax on fuel used in the mixing of cement into concrete, the off-loading of the concrete, and the loading and off-loading of solid waste will be refunded on the basis of 30 percent
of the fuel placed in the fuel supply tank of the vehicle provided proper records are maintained. Proper records shall consist of records of fills for each vehicle from tax-paid bulk storage tanks or sales tickets where fuel is purchased directly from a service station. Each vehicle must be identifiable by a unit number so the department can trace fuel usage to specific vehicles. An additional allowance will be granted where it can be substantiated through the use of separate meters which operate to measure the fuel when the vehicle is stationary or the use of separate tanks which fuel the vehicle only when the vehicle is stationary, that the actual nonhighway fuel usage exceeds 30 percent.

68.8(11) Refrigeration units (reefers). Tax paid on motor fuel and undyed special fuel is subject to refund. The person must maintain records of fuel purchases to substantiate the tax-paid purchases. Invoices must meet the criteria set forth in rule 701—67.12(452A). In addition, the invoices must separately state fuel purchased and placed in the reefer unit. Liquefied petroleum gas may be purchased tax-free for use in reefer units. See rule 701—69.10(452A).

68.8(12) Pumping credits. A refund will be allowed for taxes paid on fuel once that fuel has been placed in the fuel supply tank of a motor vehicle when the motor of that vehicle is used as a power source for off-loading procedures. Meter readings from the pump used in the off-loading procedure or the invoice, manifest or bill of lading number covering the product off-loaded must be retained. The claims for refund, unless a different amount can be proven, will be (a) one-half gallon credit for each 1,000 gallons of liquid products pumped and three-tenths of a gallon credit for each ton of dry products pumped when using motor fuel or special fuel (diesel) to power the motor and (b) one gallon credit for each 1,000 gallons of liquid products pumped and three-tenths of a gallon credit for each ton of dry products pumped when using special fuel (L.P.G.) to power the motor.

68.8(13) Transport diversions. When a transport load of motor fuel or undyed special fuel is sold tax-paid with a destination in this state and later diverted to a destination outside the state, the person who actually paid the Iowa tax is entitled to a refund. To secure a refund, the person must file a completed claim form provided by the department with supporting documentation including a copy of the bill of lading, invoices or document showing where and to whom the fuel was delivered, a copy of the reporting form and evidence of payment to the state where the fuel was actually delivered.

68.8(14) Casualty loss. In the event fuel is lost or destroyed through fire, explosion, lightning, flood, storm, earthquake, terrorist attack, or other casualty, the taxpayer must inform the department in writing of such loss within 10 days of the loss; and the notification must contain the amount of gallonage lost or destroyed which must be in excess of 100 gallons. An application for refund must be submitted to the department within 60 days of the notification and contain a notarized affidavit sworn to by the person having immediate custody of the fuel at the time of the loss or destruction setting forth, in full detail, the circumstances of the loss or destruction and the number of gallons. If the fuel was in storage where several fuel purchases were commingled, it is a rebuttable presumption that the fuel lost through casualty was a part of the last delivery into the storage just prior to the loss. No refund is allowable for fuel lost through evaporation, theft, normal leakage, or unknown causes. Leakage resulting from a major accident or catastrophe is subject to refund.

68.8(15) Exports by eligible purchasers (distributors). Distributors who have purchased tax-paid motor fuel or undyed special fuel and sell the fuel to consumers outside the state may apply for a refund of the Iowa tax paid. The distributor must retain records as provided in rule 701—67.3(452A) to support the request for refund.

68.8(16) Blending errors for special fuel. Dyed special fuel commingled with undyed special fuel and motor fuel commingled with special fuel. If dyed special fuel is inadvertently mixed with tax-paid undyed special fuel to the extent that the undyed fuel must have additional dye added to meet federal dyeing requirements to qualify as exempt dyed fuel, the tax is refundable on the undyed special fuel. The refund request must contain the number of gallons of undyed fuel lost through the mixing error and documentation as to how the gallonage was determined. If motor fuel is blended in error with dyed special fuel to produce a commingled product that must be destroyed or refined for subsequent use, the tax-paid fuel is subject to refund. The request for refund must contain documentation that the commingled product was destroyed or sold for purposes of refinement at a terminal.

68.8(17) Watercraft. Special fuel used in watercraft. This subrule is retroactive to July 1, 1996.
68.8(18) Refund of tax—Indians. Sales by Indians to other Indians of their own tribe on federally recognized Indian reservations or settlements of which they are tribal members are exempt from the tax. However, Indian sellers are subject to the record-keeping requirements of Iowa Code chapter 452A. The fuel must be purchased by the Indian seller with the tax included in the purchase price, unless the seller’s status as a particular licensee authorizes the seller to purchase fuel tax-free. The tax exemption is allowed to the Indian purchaser by the purchaser’s filing a claim for refund of the tax paid or the tribe of which the Indian purchaser is a member filing a claim for refund of the tax paid by the tribe on fuel sold to the Indian purchaser.

68.8(19) Racing fuel.

68.8(20) Benefited fire districts if the fuel is used for public purposes.

This rule is intended to implement Iowa Code section 452A.17 as amended by 2005 Iowa Acts, House File 216, and Iowa Code section 452A.71.

[ARC 5842C, IAB 8/11/21, effective 9/15/21]

701—68.9(452A) Claim for refund—payment of claim. In order to receive a refund, the claimant must hold a refund permit.

68.9(1) Persons requesting a refund for fuel used for any exempt purpose will do so by providing all or a portion of the following: (a) refund permit number, (b) type of fuel, (c) total number of gallons/tons of fuel used to calculate the refund amount, (d) the beginning and ending dates of the tax period, (e) net cost of fuel, (f) Iowa sales tax due (net cost of fuel times sales tax rate), (g) other items depending on the type of permit and claim type, (h) the total amount of refund claimed, and (i) additional information as required.

Persons requesting a refund for casualty loss, transport diversions, blending errors of motor fuel and ethanol, and blending errors of special fuel must file in writing on the forms provided by the department and must attach supporting documents explaining why a refund is due.

68.9(2) Refunds are made and the amount of the refund is paid to the person who actually paid the tax with the following exception: Persons requesting a refund for idle time, power takeoff, reefer units, pumping credits, or transport diversions may designate another person as an agent to file the claim and receive the refund. The person acting as an agent for others must provide the department with the following information including, but not limited to, the name, address, and federal identification number or social security number of the person on whose behalf they are requesting the refund. Once a person is designated as an agent, this designation remains in force until the department is notified in writing the agency agreement no longer exists. A governmental agency may designate another governmental agency as an agent for filing and receiving any tax refund authorized in Iowa Code section 452A.17.

68.9(3) Deposit of refund. If the person so designates on the application, the department will direct deposit the refund in the person’s designated bank account. If this option is selected on the application, additional forms will be provided to secure the needed information for direct deposit. In lieu of direct deposit, the permit holder will receive a state warrant.

68.9(4) A claim for refund will not be allowed unless the claimant has accumulated $60 in credits for one calendar year. A claim for refund may be filed any time the $60 minimum has been met within the calendar year. If the $60 minimum has not been met in the calendar year, the credit must be claimed on the claimant’s income tax return unless the claimant is not required to file an income tax return in which case a refund will be allowed. An income tax credit may not be claimed for any year in which a claim for refund was filed. Once the $60 minimum has been met, the claim for refund must be filed within three years.

68.9(5) A refund will not be paid with respect to any motor fuel taken out of this state in supply tanks of watercraft, aircraft, or motor vehicles or any undyed special fuel taken out of this state in aircraft or motor vehicles.


This rule is intended to implement Iowa Code sections 452A.17, 452A.19, 452A.21, and 452A.72 as amended by 2002 Iowa Acts, Senate File 2305.

[ARC 5842C, IAB 8/11/21, effective 9/15/21]
701—68.10(452A) Refund permit. To obtain the refund provided for in Iowa Code chapter 452A and rule 701—68.8(452A), the claimant must have an un canceled refund permit. The application for a refund permit is provided by the department and will contain, but not be limited to, the following information: (1) the name and location of the business and the mailing address if different, (2) the type of ownership, (3) the social security number or federal identification number of the applicant, and (4) the type of refund requested. The refund permit is issued without cost and remains in effect until revoked, canceled or until the permit becomes invalid. All refund permit holders are required to keep invoices and copies of returns if filed, supporting schedules and studies for documentation to support the refund.

This rule is intended to implement Iowa Code section 452A.18 as amended by 1995 Iowa Acts, chapter 155.

701—68.11(452A) Revocation of refund permit. The following violations will result in the revocation of the permit: (1) using a false or altered invoice in support of a claim, (2) making a false statement in a claim for refund or in response to an investigation by the department of a claim for refund, (3) refusal to submit the claimant’s books and records for examination by the department, and (4) nonuse for a period of three years. If the permit is revoked for reason (1), (2), or (3) above, the permit will not be reissued for a period of at least one year. If the permit is revoked for reason (4) above, the permit will be reissued upon proper application. (See rule 701—7.23(17A) for revocation procedure.)

This rule is intended to implement Iowa Code section 452A.19.

701—68.12(452A) Income tax credit in lieu of refund. In lieu of applying for a refund permit, a person or corporation may claim the refund allowable under Iowa Code section 452A.17 as an income tax credit. If a person or corporation holds a refund permit and elects to receive an income tax credit, the person or corporation must cancel the refund permit within 30 days after the first day of its year or the permit becomes invalid and application must be made for a new permit. Once the election to receive an income tax credit has been made, it remains in effect until the election is changed. The income tax credit is not available for refunds relating to casualty losses, transport diversions, pumping credits, blending errors, idle time, power takeoffs, reefer units, exports by distributors, and excess tax paid on ethanol blended gasoline.

This rule is intended to implement Iowa Code sections 422.110, 452A.17(2), and 452A.21 as amended by 1999 Iowa Acts, Senate File 136.

701—68.13(452A) Reduction of refund—sales and use tax. Under Iowa Code section 423.3(56), the sales price from the sale of motor fuel and special fuel consumed for highway use or in watercraft or aircraft where the fuel tax has been imposed and paid, and no refund has been or will be allowed, is exempt from Iowa sales and use tax. Therefore, unless the fuel is used for some other exempt purpose under Iowa Code section 423.3 (e.g., used for processing, used for agricultural purposes, used by an exempt government entity, used by a private nonprofit educational institution), or the fuel is lost through a casualty, the refund of taxes on motor fuel or special fuel will be reduced by the applicable sales and use tax. See sales tax rule 701—18.37(422,423). The sales price upon which the sales and use tax will be applied shall include all federal excise taxes, but will not include the Iowa fuel tax.

This rule is intended to implement Iowa Code section 452A.17.

701—68.14(452A) Terminal withdrawals—meters. Any refinery or terminal within this state must be fixed with meters which totalize the gross gallons withdrawn. All bills of lading or manifests must show the gross gallons withdrawn. A temperature-adjusted or other method shall not be used except as it applies to liquefied petroleum gas and the sale or exchange of petroleum products between petroleum refiners. All fuel withdrawn from a refinery or terminal within this state must pass through these meters.

This rule is intended to implement Iowa Code sections 452A.2, 452A.8, 452A.15(2), and 452A.59 as amended by 1995 Iowa Acts, chapter 155.
701—68.15(452A) Terminal and nonterminal storage facility reports and records. Each terminal and nonterminal storage facility operating in Iowa must file a monthly inventory report with the department. The report shall include, but not be limited to, the following information:

1. The name and license number of the company that owns and operates the terminal or nonterminal storage facility.
2. The location of the terminal or nonterminal storage facility.
3. The month and year covered by the report.
4. The terminal code assigned by the Internal Revenue Service or the storage facility license number assigned by the department.
5. The beginning inventory.
6. The total receipts for the month including for each receipt: (a) the gross gallons received by schedule code, by fuel type and, if diesel fuel, whether dyed or undyed fuel, (b) the bill of lading number, (c) the date of receipt, (d) the seller, (e) the carrier, (f) the mode of transportation, and (g) the destination state.
7. The total withdrawals for the month, including for each withdrawal: (a) the gross gallons withdrawn by schedule code and by fuel type and, if diesel fuel, whether dyed or undyed fuel, (b) the bill of lading number, (c) the date of withdrawal, (d) the consignor, (e) the consignee, (f) the mode of transportation, (g) the destination state, (h) the origin state, and (i) the carrier.
8. The actual ending inventory and any gains or losses.
9. The signature or electronic signature of the person responsible for preparing the report.
10. Such additional information as the department may require.

For periods beginning on or after July 1, 2002, the director may impose a civil penalty against any person who fails to file the reports required under the motor fuel tax laws. The penalty shall be $100 for the first violation and shall increase by $100 for each additional violation occurring in the calendar year in which the first violation occurred.

The director may require that reports be filed by electronic transmission. All licensees must file reports by electronic transmission beginning September 1, 2006.

This rule is intended to implement Iowa Code section 452A.15(2).

701—68.16(452A) Method of reporting taxable gallonage. The exclusive method of determining gallonage of any purchase or sale of motor fuel or special fuel and distillate fuel is to be on gross-volume basis. A temperature-adjusted or other method cannot be used, except as it applies to liquefied petroleum gas and the sale or exchange of petroleum products between petroleum refineries.

This rule is intended to implement Iowa Code section 452A.8 as amended by 1995 Iowa Acts, chapter 155.

701—68.17(452A) Transportation reports. The reports required under Iowa Code section 452A.15(1) are to be filed by railroad carriers, common carriers, contract carriers, distributors transporting fuel for others, and anyone else transporting fuel from without the state and unloading it at other than terminal storage within the state. The report must include all fuel which was imported into Iowa and unloaded at other than terminal storage, all fuel withdrawn from Iowa terminal storage and delivered in Iowa, and all fuel withdrawn from Iowa terminal storage and exported from Iowa. These reports must be filed monthly and show as to each delivery:

1. The name, address, and federal identification number or social security number of the person to whom actually delivered.
2. The name, address, and federal identification number or social security number of the originally named consignee, if delivered to anyone other than the originally named consignee.
3. The point of origin, the point of delivery, and the date of delivery.
4. The number and initials of each tank car and the number of gallons contained therein, if shipped by rail.
5. The name of the boat, barge, or vessel, and the number of gallons contained therein, if shipped by water.
6. The registration number of each tank truck and the number of gallons contained therein, if transported by motor truck.
7. The manner, if delivered by other means, in which the delivery is made.
8. Such additional information relative to shipments of motor fuel or special fuel as the department may require.

For periods on or after July 1, 2002, the director may impose a civil penalty against any person who fails to file the reports required under the motor fuel tax laws. The penalty shall be $100 for the first violation and shall increase by $100 for each additional violation occurring in the calendar year in which the first violation occurred.

The director may require that reports be filed by electronic transmission.

This rule is intended to implement Iowa Code section 452A.15 as amended by 2002 Iowa Acts, House File 2622 and Senate File 2305.

701—68.18(452A) Bill of lading or manifest requirements. Whenever a bill of lading or manifest is required to be issued, carried, retained, or submitted by these rules, it shall meet the following minimum requirements:
1. Contain the name and address of the refinery, terminal, ethanol plant, biodiesel plant or point of origin.
2. Contain the date of withdrawal or import.
3. Contain the name of the shipper-supplier-consignor.
4. Contain the name of the purchaser-consignee.
5. Contain the place of actual destination.
6. Contain the name of the transporter.
7. Contain the gross gallons by fuel type.
8. Contain the designation for ethanol blended gasoline or biodiesel blended fuel as provided in Iowa Code section 214A.2.
9. Contain a statement designating whether diesel fuel is dyed or undyed.
10. Have machine printed thereon a serial number of not less than four digits.

This rule is intended to implement Iowa Code sections 452A.10, 452A.12, 452A.60, and 452A.76. [ARC 8225B, IAB 10/7/09, effective 11/11/09]

701—68.19(452A) Right of distributors and dealers to blend conventional blendstock for oxygenate blending, gasoline, or diesel fuel using a biofuel.

68.19(1) A dealer or distributor may blend a conventional blendstock for oxygenate blending, gasoline, or diesel fuel using the appropriate biofuel, or sell unblended or blended gasoline or diesel fuel on any premises in this state. This subrule does not apply to the extent that the use of the premises is restricted by federal, state, or local law.

68.19(2) A refiner, supplier, terminal operator, or terminal owner who in the ordinary course of business sells or transports a conventional blendstock for oxygenate blending, gasoline unblended or blended with a biofuel, or diesel fuel unblended or blended with a biofuel shall not refuse to sell or transport to a distributor or dealer any conventional blendstock for oxygenate blending, unblended gasoline, or unblended diesel fuel that is at the terminal, based on the distributor’s or dealer’s intent to use the conventional blendstock for oxygenate blending, or blend the gasoline or diesel fuel with a biofuel.

68.19(3) This rule shall not be construed to do any of the following:
   a. Prohibit a distributor or dealer from purchasing, selling or transporting a conventional blendstock for oxygenate blending, gasoline that has not been blended with a biofuel, or diesel fuel that has not been blended with a biofuel.
   b. Affect the blender’s license requirements under Iowa Code section 452A.6.
   c. Prohibit a dealer or distributor from leaving a terminal with a conventional blendstock for oxygenate blending, gasoline that has not been blended with a biofuel, or diesel fuel that has not been blended with a biofuel.
d. Require a nonrefiner biofuel manufacturer to offer or sell a conventional blendstock for oxygenate blending, gasoline that has not been blended with a biofuel, or diesel fuel that has not been blended with a biofuel.

68.19(4) A refiner, supplier, terminal operator, or terminal owner who violates this rule is subject to a civil penalty of not more than $10,000 per violation. Each day that a violation continues is deemed a separate offense. For more information on enforcement of this penalty, see 701—subrule 10.71(8).

This rule is intended to implement Iowa Code section 452A.6A.

[ARC 1442C, IAB 4/30/14, effective 6/4/14]

[Filed 11/3/95, Notice 9/27/95—published 11/22/95, effective 1/1/96]
[Filed 9/20/96, Notice 8/14/96—published 10/9/96, effective 11/13/96]
[Filed 9/5/97, Notice 7/30/97—published 9/24/97, effective 10/29/97]
[Filed 5/11/01, Notice 2/21/01—published 5/30/01, effective 7/4/01]
[Filed 10/12/01, Notice 9/15/01—published 10/31/01, effective 12/5/01]
[Filed 10/25/02, Notice 9/4/02—published 11/13/02, effective 12/18/02]
[Filed 11/6/03, Notice 10/1/03—published 11/26/03, effective 12/31/03]
[Filed 10/22/04, Notice 9/15/04—published 11/10/04, effective 12/15/04]
[Filed 11/16/05, Notice 10/12/05—published 12/7/05, effective 1/11/06]
[Filed 12/13/06, Notice 11/8/06—published 1/3/07, effective 2/7/07]
[Filed 8/22/07, Notice 7/18/07—published 9/12/07, effective 10/17/07]
[Filed 10/5/07, Notice 8/29/07—published 10/24/07, effective 11/28/07]
[Filed 2/8/08, Notice 1/2/08—published 2/27/08, effective 4/2/08]
[Filed 10/31/08, Notice 9/24/08—published 11/19/08, effective 12/24/08]
[Filed ARC 8225B (Notice ARC 8043B, IAB 8/12/09), IAB 10/7/09, effective 11/11/09]
[Filed ARC 0251C (Notice ARC 0145C, IAB 5/30/12), IAB 8/8/12, effective 9/12/12]
[Filed ARC 0399C (Notice ARC 0285C, IAB 8/22/12), IAB 10/17/12, effective 11/21/12]
[Filed ARC 1442C (Notice ARC 1362C, IAB 3/5/14), IAB 4/30/14, effective 6/4/14]
[Filed ARC 1805C (Notice ARC 1681C, IAB 10/15/14), IAB 1/7/15, effective 2/11/15]
[Filed ARC 2247C (Notice ARC 2123C, IAB 9/2/15), IAB 11/25/15, effective 12/30/15]
[Filed ARC 2698C (Notice ARC 2619C, IAB 7/6/16), IAB 8/31/16, effective 10/5/16]
[Filed ARC 3146C (Notice ARC 3036C, IAB 4/26/17), IAB 6/21/17, effective 7/26/17]
[Filed ARC 4252C (Notice ARC 4133C, IAB 11/21/18), IAB 1/16/19, effective 2/20/19]
[Filed ARC 4585C (Notice ARC 4381C, IAB 4/10/19), IAB 7/31/19, effective 9/4/19]
[Filed ARC 5842C (Notice ARC 5710C, IAB 6/16/21), IAB 8/11/21, effective 9/15/21]
[Filed ARC 6393C (Notice ARC 6315C, IAB 5/4/22), IAB 6/29/22, effective 8/3/22]